

ACQUIRED HEARING IMPAIRMENT IN OLDER COUPLE RELATIONSHIPS:

AN EXPLORATION OF COUPLE RESILIENCE PROCESSES

by

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Dissertation submitted to the Faculty of the Virginia Polytechnic Institute

and State University in partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

in

Human Development

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April 10, 2003

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Key Words: Hearing Loss, Family Therapy, Aging, Audiology, Resilience, Coping

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(ABSTRACT)

A substantial number of older adults have acquired a hearing loss. Natural aging processes often result in gradual hearing impairment called presbycusis. Also, many adults who acquire a hearing impairment at some earlier point in their lives have to adjust to significant additional hearing losses. Because hearing loss affects basic communication processes, couples often have to adjust their ways of interacting. Extant literature presents relevant information about couple relationships in later life, individual adaptation to a hearing loss, and couple relationships where one spouse has a hearing loss. The current study was conducted to better understand the resilience processes that occur for many of these couples.

The family resilience theoretical framework guided this study (Ganong & Coleman, 2002; Walsh, 1996), with an emphasis on meaning that couples give to their experiences. The interaction of belief systems (meaning) was explored in connection with resilience processes and the development of couple relationships over time. The findings from this study represent a snapshot of the couple relationships at one point in time.

Qualitative semi-structured interviews with couples was the main method of data collection. Couples were recruited through local audiologists and through a snowball sampling method. At least one partner had to be 60 years of age or older. Each hearing-impaired participant acquired a hearing loss in adulthood or experienced a dramatic additional loss to one acquired earlier in life. Audiograms of each hearing-impaired participant were requested from doctors and audiologists, and couples completed a marital satisfaction scale.

Themes describing meaning and resilience processes emerged from interviews with eight couples in which one spouse was hearing-impaired. Themes related to meaning included couples' understanding and acceptance of the hearing loss, and demonstrations of the beliefs and values regarding their loss such as optimism, humor, gratitude, and pleasure through hearing. Resilience processes emerged in response to both individual and relational hearing-related difficulties. Couples reported having confidence in their communication skills. They also said that models of resilience, assistive listening devices, and faith in God, helped them to adapt to hearing loss stressors. In addition to what couples reported, resilience processes were observed during the interviews. Couples demonstrated healthy spousal caregiving relationships and the rebalancing of emotional ledgers during the interviews. They also reported retrospectively the development of their relationship in relation to the hearing loss.

A focus group with experienced marriage and family therapists was also conducted to obtain clinical interpretations of the themes that emerged from the couple interviews. Clinicians' responses to themes from the interviews focused on couple relationship dynamics, possible clinical situations with these couples, and the

therapist/client relationship. Therapists also viewed the focus group experience as preparatory to their working with hearing-impaired clients.

Many couples facing the hearing impairment of one spouse are living resilient lives together. However, there are likely many who are likely struggling. Implications for audiologists and marriage and family therapists are shared. Suggestions for these professionals can give some guidance to inform their work with these clients. As professionals are informed about the often unspoken and unheard stories relating to hearing loss, they can then serve with greater knowledge, empathy, and hope.

## ACKNOWLEDGEMENTS

This project would be far from complete without a word of thanks to the many people who have been influential in its creation. In expressing thanks to some, I will surely miss the many who have helped me over the years to be who I am.

First and foremost, I express gratitude for the help of my wife, Cheri L. Green Yorgason. She has done a great deal in rearing our two daughters, enduring my years of schooling, and being a support to me through thick and thin. Yet, even more pertinent to this project, she has been my transcriptionist, my proofreader, and at times my alarm clock. I truly could not list all that she has done for me in this effort! Thank you, Cheri!

Additionally, Kimberly (5) and Megan (2). They have helped me to keep my sanity with their smiles. Thank you, Kimberly, for dancing with me, coming into my office each morning for hugs, and for your prayers. Megan, thank you for running to me screaming each time I come through the door, for wanting me to hold you, and for your sweet singing voice.

Many thanks to Fred Piercy, my committee chair, for planting a seed and then nourishing it along. Thanks for your quick turnaround time with revisions, for your encouragement, and for your mentoring. You are a wonderful example of putting people before the program.

I would like to thank Susan Piercy for her audiological expertise and experience that she shared. I appreciate your support in finding couples to interview, and for your enthusiasm of my research. Thank you for the crash course in audiology and hearing loss. I appreciate you taking the time to “teach a man to fish” instead of just giving him a fish.

I would like to thank Rosemary Blieszner for her unwavering support in my gerontology education. You have been a solid mentor of my teaching, research, job searching, and other professional endeavors. You have wonderful teaching abilities – thank you for sharing with me!

I would like to thank Scott Johnson for his encouragement and vision of the future. You expressed the possibilities as ultimately unlimited. I appreciate your passion for art, literature, history, and culture, and your belief that I might know about these things too.

I thank Gary Skaggs, for graduate student-friendly statistics courses. I do not know that I would have ever taken multiple regression had I not believed I might actually understand what was being taught. I appreciate your willingness to serve on my committee, and hope that you enjoy a small taste of qualitative methodology.

I will ever be thankful for the couples that allowed me to come into their homes. They welcomed me, shared with me, and taught me most of what I know about hearing loss in later life. They are the true experts! Likewise, I thank the focus group participants who took a couple of hours out of their busy schedules to learn and to be supportive.

There have been so many other professional associates that have helped me with my graduate training. Some of them include professors for whom I have worked - Karen Roberto, Shannon Jarrott, and Alison Galway. Others have been supportive from other universities – Rick Miller, Mark White, and Jonathan Sandberg. Also, I would like to thank the many secretaries along the way. Some of them include Kathy Surface, Martha Moretz, and Geneva Watson. You are often the gears that make the world turn for graduate students – thank you!

I thank my parents, Brent and Margaret Yorgason, for their love, support, visits, and encouragement! If anyone believed I could do it, you did. Also, I thank both of my grandfathers – J.Gayle Yorgason, and Huish F. Yates. Grandpa Yates had a slight hearing loss, from what I remember, and often suffered from “recruitment” due to his grandchildren’s piercing voices. Sorry! Grandpa Yorgason showed me his new digital hearing aid the last time I visited him. Thanks for being willing to talk.

Lastly, I thank God for his support and blessings. Small miracles have been scattered along this path of graduate school. He has helped me keep perspective when the burdens were too heavy to bear. He often reminds me that life is for giving, not taking; that I have a responsibility to give to others as I have received.

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CHAPTER I

*Wife:* "What was that, dear?"

*Husband:* "Did you check the mail today?"

*Wife:* "What?"

*Husband:* "I said, did you check the mail today?"

*Wife:* "You want me to do what?"

*Husband:* "Oh, never mind! It's not that important."

*Context*

The above situation illustrates a possible interaction between spouses where one has a hearing loss. Statistics show that approximately 22 million Americans have a hearing loss, and more than 4 million of those persons are over the age of 65 (National Academy on an Aging Society, 1994). A great number of older adults that are hearing impaired sustained that loss in adulthood. The onset of hearing problems in later life, often due to normal aging processes, provides a rationale for examining this age group separate from younger counterparts.

It has been suggested that communication difficulties resulting from the loss of hearing can greatly influence couple relationships (Hetu, Jones, & Getty, 1993). This may be especially challenging for couples where one spouse acquires a hearing loss after relationship patterns become established, such as in later life. Aspects of couple relationships that may be affected range from daily couple interactions (Piercy & Piercy, 2002) to a perceived long-term impact of hearing loss. The influence of hearing loss on

couple relationships has implications for both the fields of audiology and of marriage and family therapy.

Within the audiology literature, various authors have examined the impact of hearing impairment in adulthood on couple relationships (see Hull, Jones, & Getty, 1994). For the most part, audiologists have focused their attention on psychological and social implications of an acquired hearing loss at the individual level of analysis (Abrahamson, 2001). Little empirical work has examined couple responses to hearing loss (see Hull et al., 1994). Furthermore, little is known about the meaning that couples in this situation give to their experiences and their positive and negative ways of responding within relationships. By better understanding the experiences that couples have, and their interpretation of those experiences, both audiologists and marriage and family therapists can intervene to help couples where one or both spouses experience challenges related to a hearing loss.

Within the marriage and family therapy literature, several book chapters have been written to guide therapists working with older adults (Hargrave & Hanna, 1997; Long & Mancini, 1990; Miller, Hemesath, & Nelson, 1997). A handful of studies have examined aspects of later life family relationships that therapists may encounter (Brown-Standridge, & Floyd, 2000; Garwick, Detzner, & Boss, 1994; Sandberg & Harper, 1999). Hearing loss has been mentioned in a few of these sources; however, these discussions do not provide an in-depth understanding of what couples experience when a hearing loss occurs, nor how therapists might modify their practice to treat these clients. With the expansion of medical family therapy (see McDaniel, Hepworth, & Doherty, 1997) and

the increase of older adults in the U.S., clinicians may find themselves working more with couples where one or both partners have experienced a hearing loss.

### *Conceptual Framework*

The theoretical framework for the current study is derived from the concept of family resilience. Within the fields of family therapy, family science, psychology, sociology, and others, the concept of resilience has been found useful (e.g., Coleman & Ganong, 2002; Ganong & Coleman, 2002). Different definitions for resilience have been used for research and clinical purposes. The theoretical framework for this study is informed by these definitions, with emphasis on Walsh's (2002) key processes of family resilience in clinical practice. A representation of the theoretical framework for this study is found in Appendix A.

### *Resilience Defined*

In this study, the concept of family resilience is defined as “a process by which . . . families [couples] adapt to contexts of significant adversity” (Ganong & Coleman, 2002, p. 347). Relationship processes of resilience was the focus in the current study, as opposed to what has been described as individual characteristics, traits, or protective factors (Coleman & Ganong, 2002).

Practitioners and researchers have defined the concept of family resilience differently (Ganong & Coleman, 2002). Practitioners, such as Walsh (1996), have held the opinion that all families have resilience capacities, and that clinicians can work with families to help “uncover individual and family assets and strengths” (Patterson, 2002, p. 354). Many researchers have viewed family resilience as relating to “unexpected competent functioning among families (and individuals) who have been exposed to a

significant risk(s)” (Patterson, 2002, p. 349). The difference between these two points of view could reasonably stem from respective professional backgrounds, the practitioner’s role being to work for all clients that come through the door. This is opposed to the researcher’s role of understanding similarities and differences between groups of people.

Aspects of both the practitioner and the researcher definitions of resilience were influential in the current study. In terms of the researcher definition, couples that have been exposed to the significant risk of experiencing a hearing loss were included in this study. Also, evidences of maintained positive adaptation despite adversity were assessed and explored (Luthar, Cicchetti, & Becker, 2000). The practitioner definition of family resilience was also influential, in that all couples exposed to adversity are viewed as having some resilience capacities (Walsh, 1996). In other words, greater emphasis was placed on the exploration of resilience processes within couple relationships than on determining whether a couple had adapted successfully or not.

Resilience is a process that occurs conjointly with development (Hawley & DeHann, 1996; Staudinger, Marsiske, & Baltes, 1993; Walsh, 1996). Just as stressors and competence levels can fluctuate over time and circumstances, couple resilience may change with development. For example, Staudinger, Marsiske, and Baltes (1993) shared an interesting discussion of developmental resilience processes in later life as integrated with life-span developmental psychology. They made connections between the concepts of plasticity and reserve capacity with resilience. Of direct application to the current study, Staudinger and associates (1993) discussed the possibilities of reserve capacity as being ever-changing (non-static), just as resilience processes may change with development through the life course. Thus, the process of resilience is developmental in

nature, suggesting that researchers assess the development of resilience and acknowledge the possibility of change in response to adversity over time. Based on this developmental perspective, the competence of couples in the present study was not measured as an outcome, but rather as an indicator of current functioning.

The theoretical framework for this study is also informed by Walsh's (2002) key processes of family resilience. Walsh (1998) described three keys involved in family resilience, including belief systems, organizational patterns, and communication processes. Each of these keys can be applied to couple relationships. Specifically, resilient belief systems are described by Walsh (1998) as including meaning out of adversity, having a positive outlook on life, and utilizing spirituality and transcendence as resources. She stated that resilient organizational patterns help to "define relationships and regulate behavior" (p. 79). These patterns exist when a family is flexible, connected, and able to tap social and economic resources. Resilient communication processes promote clarity in communication, open emotional sharing between spouses, and collaborative problem solving.

The experiences of the participants in this study were examined mainly in relation to the first of Walsh's (1996) keys of family resilience, belief systems. The connection between attitudes/beliefs and behaviors has been well documented in social psychology research. Specifically, one of the major themes of symbolic interactionism is related to the importance of meanings for behavior (LaRossa & Reitzes, 1993). The major concepts of symbolic interactionism have been identified as identities, roles, interactions, and contexts (LaRossa & Reitzes, 1993). These concepts are related to families experiencing adversity in that they reestablish individual and collective identities, they often develop

new roles as caregivers and/or care receivers, their resilience emerges from family processes and interactions, and all of these transformations take place within the context of significant risk.

Social psychology research has demonstrated a relationship between attitudes and behavior (see Fishbein, 1967; Kahle, 1984). One illustrative example is in the study of health care professionals' attitudes of older adults in relation to treatment rendered to this population (Singleton, Harbison, Melanson, & Jackson, 1993). In the current study, the meaning that couples give to their experiences with hearing loss was examined in relation to their resulting behavior. Specifically, the meaning that couples ascribe to their experiences was examined in relation to the resilience processes they exhibit. By describing the connections between couples' beliefs and the successful adaptations they make, clinicians and audiologists may begin to understand the experiences of these couples and be better prepared to serve them.

Patterson's (2002) explanation of meaning in connection with the Family Adjustment and Adaptation Response (FAAR) model helps to operationalize this concept. Patterson stated that, "these meanings shape the nature and extent of risk, as well as the protective capacity of a family" (p. 351). While there are multiple ways to define meaning, the three levels of meaning (modified for couple relationships) discussed by Patterson in connection to the FAAR model adds understanding this study (Patterson, 1993; Patterson & Garwick, 1994). These three levels include the way couples perceive their situation (demands vs. capabilities), the way a couple views their relationship, and the couple's world-view, or how they see themselves in relation to the world around them.

*Assumptions.* The first assumption in this study was that couples may exhibit resilience in some aspects of their relationship, and not in others (Luthar et al., 2000). Luthar and colleagues suggested that resilience does not necessitate overcoming adversity in all spheres of life, and that resilience in a single domain is noteworthy. They cautioned researchers to be specific in describing the domains to which their study pertains so that they do not imply “positive adaptation across all important areas” (p. 548).

Luthar and colleagues (2000) described three possible operationalizations of competence, including showing unexpectedly good outcomes when at risk, sustaining positive adaptation regardless of experiencing stressful life events, and recovering well from trauma. Relationship competence can be operationally defined as marital satisfaction. While some participants may not report high marital satisfaction, they may exhibit resilience in other ways. This assumption addresses the question raised by Coleman and Ganong (2002) of how practitioners might view within-family variations in response to adversity. For example, individuals may report that they communicate well with their partners, have a flexible relationship, or find meaning in their adversity, yet not be satisfied in their marriage relationships. Aspects of resilience that pertain to couple relationships, that are not captured in relationship satisfaction, will be examined by the researcher during the qualitative research process.

A second assumption in this study is that all couples that are interviewed were assumed to have experienced an adverse situation. The researcher recruited participants who had visited licensed audiologists, suggesting that couples who seek this level of care are likely to have experienced a level of hearing loss that has required some adjustment.

*Marital resilience.* Some authors have used terms such as relationship resilience and even “marital resilience,” yet the majority of studies and discussions are focused on parent/child interactions, whole family processes, and ecological (between family and community) approaches. A couple of empirical studies have examined “marital resilience.” One of these examined couple resilience to economic pressure (Conger & Rueter, & Elder, 1999), while the other examined marital resilience in response to normative, rather than non-normative stressors (Canary, Stafford, & Semic, 2002). Even within the family resilience literature, few have discussed resilience in terms of couple/marital relationships. Within the current study, couples in later life were the unit of analysis. Based on normative family life cycle stages (Carter & McGoldrick, 1999), it seems appropriate to focus mainly on the couple relationship because children are unlikely to be as involved in their parents’ lives as they were when younger. Some cultures have more permeable intergenerational boundaries, and often, younger generations act as caregivers to the elderly, yet couples who have moved beyond the child-rearing stages are likely focused on the dyad. In summary, the issue of hearing loss can influence family relationships outside of the couple and between generations, yet the unit of analysis for the current study was the couple relationship. With a focus on the couple relationship, the theoretical concept of resilience was expanded with respect to marital resilience.

#### *Role of the Researcher: Personal Reflections*

In qualitative research, the investigator is the primary instrument for data collection and analysis (Creswell, 1994). This implies that the researcher examines data through his or her own unique experiences. It thus becomes important for the researcher

to share biases and experiences that may shape or inform the research process and to build into his or her research methodology sufficient triangulation so that these biases do not obfuscate data that might emerge otherwise.

The next few paragraphs will describe my personal experiences that likely influenced the development of this study and interpretation of the data. These included exposure to hearing impairment and older adults, and the biases that these experiences brought to the present study.

### *My Family*

The experience of preparing this study exposed me to the connections that I have with hearing loss. I have personally never experienced any long-term hearing loss, although I have come to learn that both my paternal and maternal grandfathers and my own father have some hearing loss.

During my junior year of undergraduate studies I lived with my maternal grandfather. We sat and talked for hours each week, and spent a lot of time together. I vividly remember some strange occurrences with him. On the one hand, he sometimes strained to hear what I said, and on the other hand he would become extremely irritated when he heard very loud noises. I could never make sense of this behavior, but have since learned that a heightened sensitivity to loud sounds above certain thresholds can occur in hearing loss (called “recruitment” in the field of audiology). This sensitivity can be irritating and even painful for persons with a hearing loss. Sometimes I would talk with my grandfather and he would remove cotton balls from his ears to hear me better. My maternal grandfather and I never discussed hearing loss nor its implications for our

communication. I am left now with the question of what might have been different had we done so (he has been deceased for about five years now).

My paternal grandfather never complained about having problems with his hearing. I have noticed during the past few years that he wears a hearing aid. I have also noticed that he is often at the periphery of conversations when I sit and talk with my grandmother and him. I have always attributed this behavior to the personalities of my grandmother and grandfather. However, I now question whether this is due more to his hearing loss than his personality. Also, prior to this study, I had never spoken directly to my paternal grandfather about his hearing loss.

Lastly, I learned while describing this study to my father that he has suffered from a slight hearing loss in one ear from his military service in Viet Nam. He said that his "hooch" was located right next to a rocket launcher that shot rockets throughout the night, making a very loud noise. I imagine my father and I will talk about this hearing loss in the future, especially if it progresses in later adulthood. At this point, it does not seem to have affected his marital relationship in any way.

It is interesting to me that I have discovered a hearing loss experienced by so many family members. Because of these experiences, I am curious to understand hearing loss and how partners within the most intimate of relationships may experience it.

### *Older Adults*

In addition to my family experiences, my professional studies have focused on older adults. I began studying gerontology during my master's program. I found myself working on a graduate gerontology certificate and teaching a couple of undergraduate courses in adult development. During my doctoral studies, I have worked on some

research and writing projects related to later life, and worked for one year at the Adult Day Services (ADS) at Virginia Tech. While at ADS, I conducted reminiscence groups with the participants and was the leader for a support group for caregivers of persons with Alzheimer's disease. I have thoroughly enjoyed talking with these individuals and couples about their experiences in later life.

I believe that my training as a marriage and family therapist has a large impact on this study. When I sit down with a couple, I begin noticing the interactions of each spouse towards one another. I begin to see their "dance" and to discover the processes of their relationship that I would have missed before I received my clinical training. My experiences with older adults in therapy have also given me a sense of respect. I look up to older adults because of the struggles they go through, the resources they have for life's struggles, and the wisdom that they impart to me.

#### *My Observational Biases*

My experiences and personality surely color the way I see the world, and my view of hearing loss in later life. The main tendencies that seem apparent to me include my optimistic outlook on life and my respect for older adults that I have gained through my family relationships and my work as a marriage and family therapist.

I believe I do have an optimistic outlook on life. When something goes wrong I usually try to make the best of things, and I attribute the causes of such occurrences to "life" or happenstance. I have lived an extremely comfortable life, being raised in a loving home with eight siblings and having support from my family while going through trials. I also have a strong religious background, which is a great resource in my life. The positive lens with which I view the world is not always the way others view their

experiences. Therefore, I needed to be careful not to focus only on the positive in this study. For example, I had to be careful not to diminish the negative aspects of the experiences that I heard and learned from the research participants.

In summary, my personal experiences with hearing loss, my personality characteristics, and my training as a marriage and family therapist have influenced the information that I gathered in this study and my interpretation of the results. As the researcher, I have the responsibility to recognize when my personal experiences and biases may influence the data collection process and/or color the data analysis. I also had the responsibility to use multiple sources of data (e.g., observations, direct quotes, member checks, audiograms, and so forth), that allowed a fuller picture of the respondents' experiences to be captured.

#### *Purpose of the Study and Research Questions*

The purpose of the current study was to examine later life couple relationships where one spouse experienced some hearing impairment. More specifically, the aim of the study was to describe the meaning couples give to their experiences with hearing impairment and the relationship strengths perceived as leading to resilience in spite of hearing loss.

As a second part of this study, the perceptions, attitudes, and opinions of marriage and family therapists were explored as they reflected on and discussed the couples' reports. This self-reflective phase served multiple purposes. First, therapists provided clinical interpretations of the couple dynamics and shared ideas for clinical interventions with these couples. Second, therapists became familiar with the effects of hearing loss and how couples survive and thrive in the face of it.

The research questions that guided this study include the following:

- (1) What meaning (i.e., organizing or explanatory schema) do couples give to their experience of one spouse acquiring a hearing impairment in adulthood?
- (2) What relational adjustments do couples make to promote successful aging and resilience in response to the challenge of hearing loss?
- (3) How might marriage and family therapists use or support the adaptive strategies that the participants identified in therapy with clients who experience similar circumstances?

The results from this study provide a better understanding of couple resilience in the wake of hearing loss and how resilience behaviors might be used in therapy. In addition, in the spirit of participatory action research (Piercy & Thomas, 1998), the conversations that partners had with each other and the researcher about the hearing loss and the subsequent conversations by family therapists about the results, likely had an influence on the lives and relationships of both the research participants and the family therapists.

#### *Limitations*

Approximately two out of every three persons who experience a hearing impairment over the age of 65 do not seek hearing aid assistance for their difficulties (National Academy on an Aging Society, 1994). Researchers in the Berlin Aging Study (BASE) (Marsiske, Delius, Maas, Lindenberger, Scherer, & Tesch-Römer, 1999) reported that despite finding a large number of participants who experienced some hearing loss, only 16% of the sample had at least one hearing aid. The sample for the current study came from those who do seek assistance. Of course, since this is a

qualitative study, the issue of representative sampling is not so important as the identification of useful, trustworthy, heuristic themes.

### *Conclusion*

The outcome of the current study extends the research relating to couples who experience hearing loss. Several aspects of couple relationships were explored through qualitative inquiry to achieve this. The descriptions that were examined during this exploration provide direction for future research. Theoretical underpinnings of resilient responses to hearing loss were also developed. In addition, findings inform marital and family therapy for persons with hearing loss, and provide suggestions for audiologists and others who work with persons who acquire a hearing loss in adulthood. As a result, couples that experience relationship difficulties within the context of a hearing loss may encounter greater understanding regarding relationship processes.

## CHAPTER II

*Literature Review*

Literature will be reviewed for the following areas: long-term couple relationships, illness and disability and later life couple relationships, marriage and family therapy, hearing loss and audiology, and resilience. The literature that will be discussed herein will be derived from both empirical studies and clinically based writings that focus on later life and/or couple relationships.

*Long-Term Couple Relationships*

The overall focus of researchers studying long-term marriage has been on expressed affect and emotion within long-term marriages, expressions of gender within later life couple relationships, characteristics of satisfied long-term marriages, and the benefits of being married in later life (Kaslow & Robison, 1996; Levenson, Carstensen, & Gottman, 1994). The most salient pursuit of these researchers seems to be that of understanding what factors allow couples to have enduring and satisfying relationships. The following discussion of long-term marriages will be couched within the family life cycle view of marital satisfaction.

Despite conflicting results, the idea that marital satisfaction is highest early on in marriage, drops while children are in the home (for those that have children), and then rises once children leave the home, continues to surface (Anderson, Russell, & Schumm, 1983; Burr, 1973; Lee, 1988). However, few efforts have addressed the question of why marital satisfaction seems to fluctuate throughout the years (Schumm & Bugaighis, 1986). Most authors attribute the drop in satisfaction to the presence of children (Glenn, 1990), some have argued that it may be due to role strain (Lee, 1988), and others suggest

a qualitative change in the marital relationship that is not necessarily based on satisfaction (Miller, in press). In addition, higher rates of satisfaction may be due to family life cycle factors such as the "empty nest," retirement, or attrition of unhappy couples who separate before reaching later life. At any rate, couples in later life who are in long-term marriages are most likely to report that they are satisfied in their relationship (Sharlin et al., 2000).

On another note, research by Carstensen and colleagues has indicated that the expression of emotions and affect by older couples differs from that of middle aged and younger couples (Carstensen, Gottman, & Levenson, 1995; Levenson, Carstensen, & Gottman, 1993; 1994). It is interesting that in attempts to resolve important conflicts, older couples were more affectionate with one another and they expressed less emotional negativity (Carstensen, Gottman, & Levenson, 1995). They demonstrated greater positive affect and lower physiological arousal during marital interaction (Levenson, Carstensen, & Gottman, 1994). In addition, in comparison to middle-aged couples, older couples exhibited a lower potential for conflict and a greater potential for pleasure (Levenson, Carstensen, & Gottman, 1994).

Researchers also examined gender differences in middle and later life couples. Their results indicated that women were "more confronting and more affectively negative than men, who tend to be more defensive and more likely to try to escape from conflict" (Carstensen et al., 1995, p. 147). Husbands reported feeling more negative the more physiologically aroused they were; whereas wives did not (Levenson et al., 1994). Lastly, women in unsatisfied marriages reported experiencing greater health problems than those in satisfied relationships (Levenson et al., 1993). No differences in gender were found

related to age, and the majority of gender differences reported were only found in unsatisfied couples.

This literature is interesting in light of the discussions related to women becoming more independent and assertive in later life and men tending to draw closer to family ties (Long & Mancini, 1990). This redistribution of power by spouses has been said to "develop more egalitarian attitudes concerning gender-role relationships" (Miller et al., 1997). Thus, according to the Carstensen group, there seem to be no changes in marital interaction related to gender as couples get older, yet the gerontology literature suggests gender-role changes in mid- to later-life marriages.

These studies provide the groundwork for the understudied arena of couple interaction in later life. However, limitations to this research include their cross sectional nature (making it difficult to disentangle age differences from cohort effects, history, or to actual developmental changes) and the laboratory-based design (making it difficult to know whether couples interact similarly in more natural environments). While recognizing the limitations of this research, these results provide a positive introduction to the characteristics of long-term marriages.

Several lists of the dimensions of long-term satisfied marriage relationships have been created by researchers (for a review, see Kaslow & Robison, 1996). Most of these lists include characteristics such as partners having commitment to the relationship, good communication, a religious or spiritual commitment, mutual respect and trust, companionship (spending enjoyable time together), shared moral values, loyalty to one's spouse, and shared affection or intimacy. In congruence with the many positive characteristics associated with long-term marriages, benefits of being married in later life

have been described. Some of these benefits include health status (Miller et al., 1997), mental health (Sandberg & Harper, 1999), greater economic security, living longer, higher standards of living, remaining in the home longer, companionship, and receiving care from a spouse (Hess & Soldo, 1985).

Despite having experienced many things together, some marriages in later life are not necessarily happy ones (Levenson, Carstensen, & Gottman, 1994; Rubinowitz, 1999). Dickson (1997) reported common characteristics of long-term unhappy marriages. Included in her list was that divorce was not an option, couples were highly religious, the wife had a need for financial security, and couples maintained emotional and physical distance. In addition, Levenson and colleagues (1994) reported low levels of positive affect, greater negative affect, and greater negative affect reciprocity by couples who were in dissatisfied relationships as measured by the Dyadic Adjustment Scale. In summary, some long-term couples stay together due to high commitment levels, yet they remain relatively distant from one another in many ways.

Sharlin and colleagues (2000) reported on multiple studies of long-term couple relationships that had been conducted in eight different countries. They reported that the top two priorities of couples who stay together include having a "conviction that crisis is inevitable and that marriage is a partnership for life" (p. 162). Thus, couples who have been married for a long time may expect to encounter difficulties and they have the attitude that they will remain together no matter what problems they face.

*Disability in Later Life Couple Relationships*

The picture of long-term and later life marriages to this point has been fairly positive. The task now is to integrate research on disability and illness into research on satisfied, neutral, and dissatisfied later life couple relationships. In conjunction with the expectation that couples have of experiencing life crises at some point in their marriage, Huyck (1994) suggested that "illness and impairment have less impact on late-life marriages than on earlier-life marriages" (p. 194). Thus, despite the expectation for physical decline in later life, illness and disability can influence couple relationships. Indeed, Beckham and Giordano (1986) suggested that some couples in later life may experience their first severe marital difficulties. These problems may be precipitated by disabilities or chronic physical illnesses. In this section, I will review the literature regarding couple relationships and illness or disability, and marital therapy with persons who experience physical impairments, mental illness, and relationship difficulties in later life.

A myriad of possible illnesses and disabilities may encroach upon humans in later life, including both physical and mental challenges. Several researchers have acknowledged the impact that illness and disability may have on couple relationships in later life (Barth, 2000; Beckham & Giordano, 1986; Fink, Skipper, & Hallenbeck, 1968; Grand, Grand-Filaire, & Pous, 1993; Lyons, Sullivan, Ritvo, & Coyne, 1995; Rolland, 1994a; Shamoian, & Thurston, 1986; Wingfield, 1999). In addition to these discussions, a substantial body of literature exists that focuses specifically on the impact of caregiving for someone with an illness or disability (see Dwyer, 1994).

When available, the spouse is the most likely caregiver to an older adult who experiences a disability (Dwyer, 1994). When a spouse becomes a caregiver, an imbalance, disequilibrium, or change can result within the couple relationship (Beckham & Giordano, 1986; Lyons et al., 1995). Due to a shorter life expectancy for men, women are most often caregivers as spouses (Huyck, 1994). When men are placed in caregiving roles as spouses, they often view the caregiving task as a "project" to be completed, and they are more likely than women to seek assistance from formal care providers (Beckham & Giordano, 1986).

The impact that an illness or disability can have on a couple relationship may be fairly light or it may be far reaching. Dwyer (1994) suggested certain aspects of life that may be influenced, including "restrictions on activities . . . feelings of powerlessness. . . . expending their financial resources. . . . spouses . . . do experience high levels of burden and restrictions on personal freedom" (p. 413-415). When spouses become caregivers and experience some of these responsibilities, they may experience a wide range of emotions. Beckham and Giordano (1986) discussed how spousal caregivers often feel a responsibility and desire to care for their mate, and at the same time they become overburdened, they have a desire for freedom. The balance is difficult to achieve, and when not kept in check may result in a buildup of anger and hurt. Eventually, an overwhelmed caregiver may resort to abusive treatment of their loved one (Giordano & Giordano, 1983). Couples that struggle with the many demands of caregiving for a spouse may seek out professional help, especially when a crisis occurs (Brink, 1979).

Interestingly, the literature does not give much attention to illnesses or disabilities of persons who do not require a great deal of caregiving. Perhaps this is because a

caregiving role demands a much higher level of action by a spouse. Whatever the reason, it seems that there is a gap in the literature pertaining to couple relationships where a disability exists but the consequences do not reach the point of spousal caregiving for activities of daily living or instrumental activities of daily living. Of great relevance to this discussion is the fact that persons with hearing loss rarely perceive themselves as being cared for. The reason for inclusion of this section as a precursor to this study is to introduce the idea of spousal caregiving at a much less dramatic level (see Piercy & Piercy, 2002).

*Marriage and Family Therapy with Couples Who Experience Illness or Disability*

The treatment of couples who struggle with illness or disability by marriage and family therapists has been informed by two groups of literature in the field. First, therapists have conducted research with or written about illness and disabilities within the context of marriage and family therapy. Second, therapists have conducted research or written about the struggles that are specific to later life, which have included illness and disability. These bodies of literature will be reviewed here.

During the past decade or so, the field of family therapy has expanded its horizons to include working with clients in medical settings. Therapists may have worked in these settings prior to the 1990's, but the practice has become more common in the recent years (McDaniel et al., 1997). This trend for marriage and family therapists has advanced the work that many clinicians do with families and couples who experience illnesses and disabilities. Possibly as a result of the medical family therapy model, multiple clinicians have written about therapy applications to families who experience health difficulties (see Rolland, 1994b). Some of these include immunological breakdown associated with

negative behavior during marital conflict (Keicolt-Glaser, Malarkey, Chee, & Newton, 1993), terminal cancer in one spouse (Rolland, 1997), and hearing loss in one spouse (Piercy & Piercy, 2002). At the same time, some book chapters have focused on family therapy with persons who experience chronic physical illness (Barth, 2000), and families, illness, and disability (Rolland, 1994a).

While these writings shed light on couple relationships in which illness and disability occur, they are either very specific to certain situations, or so broad that they leave little room to facilitate in-depth discussions regarding couple relationship dynamics. Further research regarding marriage and family therapy with families and couples who experience illness and disability could build upon this foundation. Rolland (1994b) acknowledged this gap in the literature and supplemented the existing materials with an article that describes several couple issues related to illness within marital relationships. Some of the issues include intimacy, communication, boundaries, externalization, triangulation, caregiver roles, togetherness and separateness, gender, sexuality, belief systems, and the life cycle. While the ideas that Rolland (1994b) shared seem to be geared towards couples who experience a terminal illness or an illness that requires caregiving to a large degree, it remains to be shown how these issues may apply to couple relationships where a hearing loss is present.

A number of marriage and family therapists have written compilations of clinical applications regarding their work with later life couples (Greenbaum & Rader, 1989; Hargrave & Hanna, 1997; Long & Mancini, 1990; Miller et al., 1997). Within this growing body of literature are multiple discussions of how illness and disability may influence marital relationships in later life. Most of the literature focusing on marital

therapy with couples in later life is based on clinical observations, rather than empirical studies. Despite having little empirically tested knowledge, therapists can gain valuable insights from these clinical writings.

In a study performed by Van Amburg, Barber, and Zimmerman (1996), approximately 10 years of marriage and family therapy journal articles were examined to see what attention had been paid to later life issues. The authors found that when "an older adult was the IP [identified patient], the concerns most often presented related to spousal caregiving" (p. 200). This finding should become a red flag for therapists who currently work with or expect to work with older couples in the future. Similarly, Greenbaum and Rader (1989) reported on marital problems of the oldest-old (those over 85 years of age) who presented themselves for treatment to a mental health clinic. In their discussion, they again brought up the issue of spousal caregiving. Based on the repeated mention of marital problems related to caregiving, and the low utilization of mental health services by older adults, marriage and family therapists might do well to explore caregiving issues with couples in later life where one spouse experiences physical ailments.

Other discussions of physical illness or disability in context of later life couples include an examination of health, retirement, and family functioning on morale in later life couples (Bishop, Epstein, Baldwin, Miller, & Keitner, 1988), a discussion of biological and physical aging (Hargrave & Hanna, 1997), and a discussion of the effects of major illness on marriage (Miller et al., 1997). These writings review general information about physical decline in later life and relevant relationship issues that have been discussed previously. Yet, because there is so little family therapy literature that

addresses illness and disability in later life, these discussions have been made to cover very broad issues that therapists may encounter, rather than an in-depth consideration of these issues.

Lastly, Beckham and Giordano (1986) discussed "illness and impairment in elderly couples" along with suggestions for marital therapy (p. 257). In relation to therapy, these authors discussed (a) that barriers keep older adults from receiving psychotherapeutic treatment, (b) that older couples experience similar difficulties to young and middle aged couples, (c) that therapy with older adults is often more helpful with therapists who are at least middle aged, (d) that not all problems in later life are irreversible, and (e) that therapists need to be aware of community referrals for older clients. In relation to working with couples who experience an illness, Beckham and Giordano (1986) suggested that therapists explore boundaries in the couple relationship related to caregiving roles, and that they reassure the spouse with the disability that they are there to help (this will decrease the likelihood of the impaired spouse feeling like the therapist is joining more with the healthy spouse). They encouraged therapists to collaborate with medical professionals to ensure the best care for these clients.

It is interesting to note the small number of suggestions for couples throughout all of the marriage and family therapy literature related to couple relationships and caregiving. Most of what has been written either acknowledges the difficulties or gives specific examples of what individual clinicians have done to treat specific cases. While clinical suggestions for working with older adults are available, very few discussions have been specifically directed toward couples. In reference to this critique, couple stories shared in the current study will be analyzed to better understand the processes

involved in the couple interactions. This information can be valuable for therapists working with older clients. By directly asking clients of their experiences, the encouragement made by Johnson and Lebow (2000) to ask the "clients themselves about the process of change . . . and so honoring what couples have to teach us about the regularities and the unique, particular aspects of this process [change]" will be heeded (p. 33).

### *Hearing Loss and Audiology*

Within the broad arena of hearing loss, several specific topics have relevance to the current study. The physical aspect of aging and hearing loss will first be reviewed, followed by a discussion of possible barriers to using hearing aids. Some audiology literature that addresses the effects of hearing loss on couple relationships will then be discussed.

#### *Physical aging and hearing loss*

Approximately eight percent, or 22 million, Americans experience a hearing loss (National Academy on an Aging Society, 1994). About four million among those with a hearing loss are persons over the age of 65 (National Academy on an Aging Society, 1994). Researchers in the Berlin Aging Study (BASE) (Marsiske et al., 1999) found that participant's ability to hear was negatively associated with age. In addition, men experienced a hearing loss more often than women.

The normal decline in the ability to hear with age is called presbycusis. Presbycusis can be linked to both peripheral and central auditory functions (see Jerger, Chmiel, Wilson, & Luchi, 1995). The peripheral loss occurs within the cochlea of the inner ear, and usually results in decreased sensitivity to pure tones of higher frequencies

(Spence, 1995). In other words, people lose the ability to hear higher-pitched sounds. This decline usually occurs in both ears, although not necessarily at the same rate (Jerger et al., 1995). In addition, presbycusis may be accompanied by a decreased ability to understand speech (Villaume, Brown, & Darling, 1994). A lessened ability to discriminate speech has been linked to the "central processing of auditory information," as well as to a damaged cochlea (Jerger et al., 1995, p. 930). In a central impairment, people may have a difficult time understanding what is said due to a decline in the processing speed of the auditory centers in the brain (Hull, 1989).

Several other reasons for hearing loss that are not a part of normal aging, but may be more prevalent in later life, may also influence the ability to hear well. Some of these include: (a) tinnitus - a constant ringing sound in the ears that masks the speech of others, (b) ear infections, (c) Meniere's disease, (d) and noise exposure. Whether or not the hearing loss results from one of these factors or from the effects of aging, the life of the person who experiences the loss and those around her is influenced. Because hearing is a vital component of communication, not only are the communication skills of persons with hearing loss affected, but those individuals involved in the lives of the hearing impaired are influenced as well. It should also be noted that not all older adults experience a significant hearing loss, and many older adults with a slight hearing loss seem able to function well without amplification of any kind.

### *Hearing Aid Use*

According to the National Academy on an Aging Society (1994), two thirds of persons over the age of 65 with a hearing loss do not use hearing aids. The positive side of this negative is that, "Most hearing aid users – 71 percent – are age 65 and older"

(National Academy on an Aging Society, 1994, p. 5). The fact remains that only 20% of adults with a hearing loss who could benefit from using hearing aids actually use them (Ross, 2002). Barriers to wearing hearing aids as well as benefits that come from wearing them will be discussed.

When older adults who don't wear hearing aids were surveyed, they reported that the reasons for not using aids included the high cost of hearing aids, a perceived stigma connected with wearing a hearing aid, and poor performance of hearing instruments (O'Neil, Summer, & Shirley, 1999; National Academy on an Aging Society, 1994). Predictors of hearing aid use include (a) more severe loss, (b) higher education, and (c) lower quiet condition word recognition scores (Popelka, Cruickshanks, Wiley, Tweed, Klein, & Klein, 1998). Identified correlates with hearing aid use include (a) high impact of hearing loss on activity, (b) Caucasian race, and (c) living alone (Tomita, Mann, & Welch, 2001).

Some have suggested that the greatest barrier to hearing aid use is the problem of attitude and/or a person's view of the problem (Ross, 2002; Stephens, 1995). Similarly, four different personality types and their possible reactions to a hearing loss have been identified (Piercy & Goldstein, 1994). These personalities range from "Type I: Strong Positive," where a person has no problem with their rehabilitation, to "Type IV: Strong Negative," where the hearing impaired individual denies the extent of the disability and rejects hearing instruments. Piercy and Goldstein (1994) noted that the "Type III: Essentially Negative" personality was one where the person with the hearing loss may be most amenable to change when urged by a spouse to seek help. Many experts believe that

it is important to involve the spouse (when available) in aural rehabilitation (Doherty, 1985; Kaplan, 1985; McCarthy, Montgomery, & Mueller, 1990; Miller, 1984).

Stephens and Meredith (1991) identified common benefits of hearing aid use, including increased satisfaction in watching television, general and individual conversations, and hearing in church meetings. Other benefits have been studied in connection with audiologic rehabilitation. These benefits have included participants' increased ability to use coping strategies, experiencing a change in attitude towards and perspective of the hearing impairment, and greater comfort in using hearing aids (Backenroth & Ahlner, 2000). In the present study, the use of hearing aids and other assistive listening devices was explored, as well as the influence that spouses have on the use of these devices.

#### *Family Relations within the Audiology Literature*

In 1976, Oyer and Hardick counseled, "To date we have paid all too little attention to the effects of hearing handicap on the basic unit of society, the family" (p. 62). Since that statement was made, some researchers have attempted to fill the void. Within the audiology literature, several studies have examined the responses of individuals to hearing loss in later life in connection with family relationships (Andersson, Melin, Lindberg, & Scott, 1995; Hallberg & Carlsson, 1991; Vesterager, Salomon, & Jagd, 1988). These studies usually acknowledged the impact of hearing loss on family and couple relationships, although their primary focus is often on individual psychological and non-familial social reverberations. The understanding of couple relationships that was gained from these studies will be discussed in relation to other

nonempirical writings of the same topic. In addition, the audiology literature that focuses on occupational hearing loss and marital relationships and hearing loss will be reviewed.

*Sociological and psychological factor.* Early audiology literature that acknowledged an impact of hearing loss on interpersonal relationships was focused on psychological and sociological factors. O'Neil, Summer, & Shirley (1999) identified social and psychological implications of hearing loss. They included depression, life dissatisfaction, reduced health, and withdrawal from social activities. In addition, audiology researchers, in discussing psychological and sociological implications of hearing loss, identified possible effects on family relationships (e.g., Alpiner, 1964, 1978; Jones, Kyle, & Wood, 1985; Thomas, 1984). For example, Thomas (1984) found that research participants who reported that hearing loss had influenced the family, were more likely to experience psychological problems. He also reported that severe hearing loss may be related to considerable family stress.

Various psychological and sociological implications of a hearing loss and coping strategies used to deal with these situations have been identified. Some have suggested that hearing loss can affect intimate relationships, partners may judge the handicap of hearing loss more or less severely, persons with a hearing loss may not realize the impact their loss has on others, and early identification and evaluation is desirable (Jerger et al., 1995). In addition, face-to-face communication was only hampered when a severe hearing loss was present (Vesterager, Salomon, & Jagd, 1988). As a coping strategy, persons with hearing loss may attempt to avoid social situations or control them (Hallberg & Carlsson, 1991). In addition, to enhance sexual relationships, it has been suggested that the hearing impairment be accepted, understood, and discussed (Reiter,

1987). These issues seem relevant, and the coping strategies applicable, yet they are very general in the sense that they may vary depending on the context of the relationship. The current study helps fill this gap in the literature by describing specific aspects of couple relationships where one spouse has a hearing loss.

*Marital relations and hearing loss.* Hunter (1978) surveyed a group of adults who had experienced a hearing loss in adulthood, 50% of which reported having been divorced (as cited in Orleans, 1985, p. 43). Beattie (1981) found that a significantly higher number of husbands, as opposed to wives, reported that hearing loss had affected their marriage. She reasoned that these sex differences could be due to husbands with a hearing loss having to assume greater dependence upon their wives. Congruent with these findings, Kyle and Wood (1983) found that 86% of their sample who acquired a hearing loss reported that the loss had placed a strain on their family relationships. These findings suggest that husbands and wives who acquire a hearing loss (and their respective partners) may experience and adjust differently to the loss due to their social roles and expectations.

*Occupational hearing loss.* One group of researchers targeted couple relationships related to occupational hearing loss (Getty & Hetu, 1991; Hetu & Getty, 1991; Hetu, Lalonde, & Getty, 1987; and Hetu, Riverin, Lalonde, Getty, & St-Cyr, 1988). The adults in these studies often acquired a hearing loss in adulthood due to working in a setting where high intensity noise was present.

In an investigation of 61 employees of a metal product plant, workers and their spouses were interviewed regarding the effects of hearing loss (Hetu et al., 1988). Findings indicated that workers had to give extra effort in communicating, they

experienced anxiety and stress when communicating, they experienced changes in their social activities, felt isolated when in groups, and at times had a negative self-image. The researchers discussed how these problems also influenced spouses of these workers. In response to this and other studies, Getty and Hetu (1991) developed an aural rehabilitation program for couples where one spouse had acquired an occupational hearing loss. They conducted a group intervention that consisted of four weekly meetings, a 1½-day weekend session, and an evaluation meeting. The researchers included spouses in the intervention. Findings from the groups suggested that workers reported their hearing loss to be less severe following the sessions; they felt more confident in their communications; and they took steps to improve their situation by telling others of their impairment, requesting help in communicating from conversational partners, and obtaining hearing aids.

Lastly, as a continuation of their work, Hetu (1993) published an overview of the literature addressing the effects of hearing loss on intimate relationships. The most salient points made in this review include; (a) hearing loss was not found to be associated with marital breakdown, (b) the gradual onset of acquired hearing loss in later life may lead to shared problems, but unshared solutions, (c) each spouse needs to receive support in their personal view of the situation, (d) the needs of both partners should be recognized in the audiological rehabilitation process. Within her suggestions for a model of aural rehabilitation, couples were encouraged to meet together with the audiologist or in group settings with spouses present. Hetu and colleagues have paved the way for further studies that examine couple relationships. Their audience is the field of audiology, yet many of their suggestions are applicable to marital therapy situations.

*Resilience*

The variety of adjustments people make to unexpected life experiences covers a wide range of possibilities. Resilience has been defined as "the capacity to rebound from adversity strengthened and more resourceful" (Walsh, 1998, p. 4). The foundation for this movement of research was in response to deficit-based models, being grounded in the concept of "soluto-genesis" – suggesting a focus on how families remain healthy, rather than how they become ill (Antonovsky, 1987). To review relevant literature on resilience, a history of the study of resilience will be presented, followed by a discussion of critiques that have been offered on the concept of resilience.

*History of resilience.* The concept of resilience has an evolving history in the social sciences, pioneered by psychologists and psychiatrists who found some children who "developed well" despite adversity (Garmezy, 1971; Murphy, 1974; Werner & Smith, 1982). These and other researchers focused their attention on personal characteristics or traits of children who demonstrated well being in the face of adversity. Recent efforts to clarify definitions of resilience have labeled the above focus on inherent individual strengths as 'resiliency' (Coleman & Ganong, 2002).

In contrast to individual 'resiliency,' definitions of competent adaptations to risk and adversity based on relationship processes have most recently been termed 'resilience' (Coleman & Ganong, 2002). The process-oriented approach to resilience emerged as researchers chose to examine relationship processes found in families and communities rather than individual traits (Ganong & Coleman, 2002; Walsh, 1996, 2002). Walsh (2002) described a basic guiding premise to this approach as "stressful crises and persistent challenges influence the whole family, and in turn, key family processes

mediate the recovery and resilience of vulnerable members as well as the family unit” (p. 130).

In addition to the resiliency vs. resilience clarification, recent discussions have differentiated practitioner definitions of resilience from researcher definitions of resilience. Patterson (2002) described the practitioner view as focusing on strengths rather than deficits, whereas the researcher approach is described as measuring “outcomes to explain unexpected competent functioning among families (and individuals) who have been exposed to significant risk(s)” (p. 349). Thus the “practitioner” view holds the assumption that all families have potential for resilience, it only needs to be explored with them, while the “researcher” view assumes that only certain families will be resilient in the face of adversity. For a more complete history of the concept of resilience, see recent articles by Coleman and Ganong (2002), Ganong and Coleman (2002), and Hawley, (2000).

*Family resilience.* Several authors have developed theoretical discussions of the family resilience concept (Coleman & Ganong, 2002; Ganong & Coleman, 2002; Hawley, 2000; Hawley & DeHaan, 1996; McCubbin, McCubbin, Thompson, Han, & Allen, 1997; Patterson, 2002a, 2002b; Walsh, 1996, 2002). However, few empirical studies examining family resilience have been published.

One research emphasis of family resilience has focused on the Resiliency Model of Family Stress, Adjustment, and Adaptation (McCubbin & McCubbin, 1993, 1996, 1998; Patterson, 2002a). Despite several theoretical discussion of this model, limited research has incorporated it empirically (see McCubbin et al., 1997, for a review of studies that support the idea of family resilience yet are based on some alternative

theoretical framework, e.g., stress and coping). In one study of 26 families where a child had been diagnosed with cancer, six family resiliency factors were identified by McCubbin, Balling, Possin, Friedrich, and Bryne (2002). These factors included (a) the internal family strengths of rapid mobilization and reorganization, (b) support from the health care team, (c) support from extended family, (d) support from the community, (e) support from the workplace, and (f) changes in family appraisal. This study is one of the few that have actually collected data with the 'family' as the unit of analysis. Future studies might seek to collect family level data on resilience processes.

Rand and Katherine Conger and colleagues have established a research group in Iowa that has focused its efforts on family resilience in the face of economic hardship (see Conger & Conger, 2002). The results from two of their studies (Conger & Conger 2002; Conger, Rueter, & Elder, 1999) have indicated that family resilience is experienced in relation to economic hardship when spouses support each other emotionally and use effective problem solving skills. In addition, when parents were nurturant and involved in their adolescent's life, they helped the youth to be resilient to economic stress and to the life transition from adolescence to adulthood. These studies indicate the importance of spousal support and effective problem solving skills in marital relationships. They also provide evidence of resilience when parents are lovingly involved in their teenagers' lives.

A final empirical focus has been on family resilience in response to daily hassles or normative events, as opposed to non-normative stressors. One study examined couple maintenance strategies (positivity, assurances, openness, networks, sharing tasks) and relational characteristics (liking, commitment, control mutuality) in reference to the daily

challenges of 150 couples (Canary, Stafford, & Semic, 2002). The researchers found that maintenance strategies were related to relational characteristics, yet their efficacy depended upon their continued use. The researchers suggest that maintenance strategies may moderate the effects of exposure to risk and competence (Canary et al., 2002). A second study, related to daily hassles, assessed the intimacy and marital quality of 472 later life couples. The researchers of this second study were not specifically addressing resilience, yet it is interesting to note that intimacy mediated the relationship between daily stress and marital quality for both husbands and wives (Harper, Schaalje, & Sandberg, 2000). Thus, a number of important 'resilience' factors associated with marital relationships have been identified. Further research could help to establish these processes and characteristics in the study of resilience and resiliency in couple relationships.

*Critiques of the resilience concept.* Luthar and colleagues, (2000) presented a critical evaluation of the concept of resilience. Their critiques are grouped into four categories: "(1) ambiguities in definitions and terminology, (2) variations in interdomain functioning and risk experiences among ostensibly resilient children, (3) instability in the phenomenon of resilience, and (4) theoretical concerns, including questions about the utility of resilience as a scientific construct" (p. 543).

Coleman and Ganong (2002), as well as others, have suggested that researchers and practitioners be specific with their use of terminology related to resilience in order to lower confusion in the field. Specifically, Luthar et al. (2000) suggest general uses for terms such as resilience vs. resiliency and protective vs. vulnerability factors. In addition, the operationalization and measurement of resilience has varied widely, making it

difficult to compare results across studies. One general suggestion in response to these critiques is that those who write about resilience need to be overt in defining the terms that they use. Researchers also need to be specific in describing how they define risk, competence, and they need to justify their decisions (Luthar et al., 2000). Some have suggested that resilience adds little to the concept of positive adaptation to adversity (i.e., stress and coping paradigm). Defenses to this critique have argued their stance by differentiating between positive outcomes in the face of adversity vs. positive outcomes where normative experiences occur (Luthar et al., 2000). Patterson (2002) stated that “in many ways, the concepts that underlie it [resilience] are already contained in family stress theory, a focus on resilience draws greater attention to family success and competence” (p. 358). Thus, the problems that have been identified regarding the concept of resilience are valid critiques. However, suggestions stemming from the critiques can bring uniformity across disciplines regarding terminology and can bring understanding as research endeavors diversify.

### *Conclusion*

In summary, the literature focusing on couples in long-term relationships, illness and disability, marriage and family therapy, audiology, and resilience pertain to the current study. They provide a context in which to view hearing loss in the lives of later life couples.

## CHAPTER III

*Methodology*

The purpose of this research study was to examine couple relationships in which one spouse has acquired a hearing loss in later life. By using a qualitative method of inquiry, I explored the meaning couples give to their experiences related to hearing loss, how couples promote resilience despite their challenges related to the impairment, and how marriage and family therapists respond to the interaction processes of these couples. Quantitative marital satisfaction data and hearing impairment records were also collected and used to describe the situations of the research participants.

The major portion of the current study was carried out using a basic qualitative design (Merriam, 1998). This approach was used for a number of reasons. First and foremost, while the focus of family therapists on older adults is expanding, very little empirical exploration of later life relationships has been performed by family therapy researchers. In addition, within the audiology literature, several authors have suggested that qualitative methods be used to examine couple relationships where hearing loss is present, and to include both spouses in the investigation (Hetu, 1993; Hetu, Lalonde, & Getty, 1987). While a grounded theory method was not used in this study, some theoretical concepts and abstractions were found that can be applied in future research (Creswell, 1994). Also, while not strictly phenomenological in nature, this study was aimed at exploring the meaning that couples give to their experiences. By listening to their experiences first hand, I was able to explore the meanings that participants gave to their experiences. In addition, couple resilience processes were explored.

### *Focus Groups*

As a second part of this study, a focus group was held with therapists to explore their responses to the couple dynamics revealed through couple interviews. Focus groups are planned discussions with a small number of participants, guided by a skilled interviewer (Krueger, 1994). As Piercy and Nickerson (1996) have suggested, focus groups are intended to provide a non-threatening environment where participants can share their views, opinions, and ideas on the topic at hand. Krueger (1994) discussed six advantages to using focus groups to gather research data. These advantages included (a) group dynamics can lead to creative, practical, and diverse pathways; (b) the focus group format allows the researcher to ask additional, unplanned questions; (c) focus groups have a high face validity; (d) focus groups can be relatively inexpensive; (e) focus groups can provide quick results; and (f) focus groups allow qualitative researchers to access larger sample sizes than might otherwise be possible.

The purpose of focus group in the current study was to create a bridge between couples in later life who are adjusting to a hearing loss and the clinical practice of marriage and family therapy. Therapists were asked how the resilience factors identified in the present study (as well as other results) might be used in therapy with hearing impaired clients and their spouses.

### *Sample*

Potential couples were contacted through local audiologists and then through a snowball sampling method. Audiologists were included in the recruiting process because (a) therapists may receive referrals from audiologists, and (b) relatively few persons with hearing loss seek help from an audiologist, suggesting a severe level of impairment and

also suggesting a willingness to improve their situation. A recruitment flier was mailed or given to audiologists in the area. The audiologists provided brief details about the project to their clients, and told them to contact me if they were interested in participating in the project (See Appendix B). Due to the difficulty of reaching couples where one spouse has a hearing loss, a snowball sampling method was also used. Potential couples were recruited through my acquaintances, who then suggested other couples they knew. Participants were selected based on the criteria of (a) acquiring a hearing loss as an adult and while living within the current marital relationship or experiencing a dramatic hearing loss after the formation of the current relationship, (b) having sought help from an audiologist or hearing aid dealer – thus helping to determine severity of the impairment, (c) having at least a self defined “mild” hearing impairment, and (d) being over the age of 60, in order to connect later life issues with the experiences of the participants.

I personally invited a total of fourteen couples to be interviewed in this study. Five of these declined to participate (e.g., one couple said that they did not feel they had adjusted well to the hearing loss and so they declined to participate), leaving nine couples to be interviewed. One interviewed couple was excluded after it was determined that they did not meet the inclusion criteria for this study. This couple did not meet the age criteria (they were 55 and 56 years old), and their experiences seemed very different from those of other couples in the study, in that both spouses had significant hearing losses throughout their relationship (the husband had a complete hearing loss in one ear since birth, and the wife had a hearing loss since early childhood). The final sample consisted of eight couples. One of these couples was referred from an audiologist, and the other 7

were recruited using the snowball method. Of the couples in this study, five of the hearing-impaired spouses were the wives and three were the husbands. In addition, at least 3 of the non-impaired spouses reported that they thought they might have a hearing loss. This study focused mainly on the experiences of the couple in relation to the spouse with the most severe level of hearing loss. The current sample was very highly educated, came from the middle to upper socioeconomic status, and they had access to audiologic resources such as audiologists, advanced technology in hearing aids, and so forth.

Contextual demographic characteristics of the couples is shown in Table 1.

Table 1. Participant characteristics.

Age	Years Married
4 couples in their 60s	1 couple 10 years <sup>a</sup>
4 couples in their 70s	1 couple 22 years <sup>a</sup>
	6 couples between 37 and 51 years
Education	Professions
2 – High School	Merchandising
2 – Business or Vocational College	Clothing and Textiles
1 – Associate’s Degree	Accounting
4 – BS degrees	Academic Professor
2 – MS degrees	School Teacher
5 – PhD degrees	Artist
	Homemakers/mothers
	Telecommunications

<sup>a</sup>In second marriage

Participants signed an informed consent form to allow access to audiology records (See Appendix C). The records were used to determine the severity of the hearing loss.

Participant audiograms showed the type, severity, shape, and level of speech discrimination. The different types of hearing loss include (a) conductive: related to problems in the outer and middle ear, (b) sensorineural: related to problems in the inner ear, the 8<sup>th</sup> nerve, and/or the auditory centers of the brain, and (c) mixed: a combination

of both conductive and sensorineural losses. The shape of a hearing loss describes the configuration of pure tone responses on an audiogram, indicating hearing loss at specific sound frequencies. The hearing loss frequency patterns of the participants in this study were shaped in the following ways: Flat (little difference in loss across sound frequencies), sloping (usually with better hearing at lower frequencies that gradually worsens at higher frequencies), fragmentary (some frequencies are not discernable), notched (hearing at one or more frequencies is significantly poorer than at other frequencies), and precipitous (a very steeply sloping hearing loss with less hearing sensitivity at the highest frequencies). Speech discrimination describes the ability to hear OK and recognize words presented in an audiologic setting.

Each of the research participants had met with an audiologist at some point for a hearing examination. As shown in Table 2, the participants of the current study had degrees of hearing loss that ranged from mild to profound. Speech discrimination levels also varied across the spectrum. The shapes of the hearing loss experienced by the research participants varied, yet generally indicated a lesser ability to hear higher pitched sounds. Also shown in the table, it was found that all of the research participants had experienced a sensorineural hearing loss. In other words, none of them suffered from hearing loss caused solely by damage to the outer or middle ear. Implications of these descriptors are shared in the discussion section.

The sample of the family therapist focus group included five marriage and family therapists. Two of the therapists worked for several years in private practice, while three of them were doctoral students.

Table 2. Audiologic Diagnostic Results: Descriptions of hearing loss for hearing impaired spouses.

<b>Participant Pseudonyms for Spouse with Loss</b>	<b>Time Since Onset of Loss</b>	<b>Specific Ear</b>	<b>Degree of Loss</b>	<b>Shape of Loss<sup>a</sup></b>	<b>Type of Loss<sup>b</sup></b>	<b>Speech Discrimination<sup>c</sup></b>
Alice Akers (Wife)	60 years	Right	Profound	Fragmentary	Sensorineural	CNT <sup>d</sup>
		Left	Profound	Fragmentary		
Melanie Stephenson (Wife)	4 years	Right	Mild	Precipitous	Sensorineural	Fair
		Left	Profound	CNT		CNT
Stacey Johnson (Wife)	10-12 years	Right	Moderate	Sloping	Sensorineural	Good
		Left	Moderate	Sloping		Good
Louise Jones (Wife)	3 years	Right	Mild	Sloping	Sensorineural	Excellent
		Left	Mild	Sloping		Excellent
Jerry Gardner (Husband)	20 years	Right	Profound	Fragmentary	Sensorineural	CNT
		Left	Moderate to Severe	Fragmentary		Good
Hugh Daines (Husband)	20 years	Right	Moderate to Severe	Flat	DNT <sup>e</sup>	Fair
		Left	Moderate to Severe	Notch		Poor
Jackie Poresky (Wife)	30-40 years	Right	Moderate to Severe	Flat	DNT <sup>e</sup>	Fair
		Left	Moderate to Severe	Flat		Fair
Jack Green (Husband)	70 years	Right	Severe	Precipitous	Sensorineural	Poor
		Left	Profound	Sloping		Poor

<sup>a</sup> Shape describes configuration of pure tone responses on audiogram

<sup>b</sup> Conductive, Sensorineural, or Mixed

<sup>c</sup> Levels of Speech discrimination, based on word recognition percentages [Excellent 95%, Good 90%, Fair 80%, Poor < 80%]

<sup>d</sup> CNT = Could not test

<sup>e</sup> DNT = Did not test

### *Procedure*

In-depth, semi-structured interviews with couples were conducted to answer the first two research questions (See Appendix D). Interviews lasted an average of two hours. Each spouse signed an informed consent form to confirm their understanding of the research purposes and procedures (See Appendix E).

Couples were asked to describe their experiences surrounding the hearing loss, especially those related to their relationship. Open-ended questions were used to explore the belief system that couples use to understand the hearing loss. That is, couples were asked about how they “make sense” of hearing loss and whether it has any greater meaning for them and their relationships. In addition, they were asked about what they believe does or could help them to thrive in their relationship despite the hearing impairment. Lastly, I explored issues with individual spouses that they may have felt less comfortable discussing with their partners listening. This was done by asking individuals if they had anything else they would like to share (while the spouse was out of the room).

Following each interview, the researcher wrote field notes in a research journal to record impressions from the interview regarding couple processes, the context of couples’ lives, and prevalent interview themes. In addition, entries were periodically made throughout the research process to record thoughts, ideas, and reactions to the research process. The integration of field notes and journal entries is discussed in the analysis section.

### *Measures*

*Marital satisfaction.* The Kansas Marital Satisfaction Scale (KMS) was used to assess marital quality of the research participants in this study (See Appendix F). The

KMS (Schumm et al., 1986) is composed of three items that ask (1) "How satisfied are you with your marriage?," (2) "How satisfied are you with your relationship with your wife/husband?," and (3) "How satisfied are you with your husband/wife as a spouse?" (Ja Jeong, Bollman, & Schumm, 1992). Each question is answered by choosing one of seven responses that range from "extremely dissatisfied" (a score of one) to "extremely satisfied" (a score of 7). Total scores can range from three (extremely high dissatisfaction) to 21 (extremely high satisfaction). Scores of 17 and below have been established as indicating clinically distressed relationships (Crane, Middleton, & Bean, 2000).

The KMS is a brief measure of marital quality. Several research studies have been carried out by Schumm and colleagues to establish validity and reliability for this measure. Research has given support to its construct validity (Ja Jeong, Bollman, & Schumm, 1992), and criterion validity (Schumm et al., 1985). Research has established concurrent validity with Spanier's Dyadic Adjustment Scale (Spanier, 1976) the Quality Marriage Index (Norton, 1983), and the Locke-Wallace Marital Adjustment Test (Locke & Wallace, 1959) (Grover, Paff-Bergen, Russell, & Schumm, 1984, White, Stahmann, & Furrow, 1994). In addition, test-retest reliability ( $r = .71$ ) (Mitchell, Newell, & Schumm, 1983), and internal consistency reliability ( $\alpha \leq .84$ ) (Schumm et al., 1985) have been established. In addition to these statistical demonstrations of reliability and validity, the KMS has been shown to be a useful measurement instrument in assessing marital satisfaction in later life couples (Herman, 1994). Lastly, studies using the KMS to measure marital satisfaction in later life couples, have found no evidence that this

measure cannot be used reliably and validly with older adults (Harper, Schaalje, & Sandberg, 2000; Herman, 1994).

*Focus group questions.* Once the couple interview transcripts were analyzed, the most salient themes and categories were presented to a focus group of marriage and family therapists (See Appendices G, H for recruitment messages, and I for the informed consent). Specifically, a case vignette was shared with the group, and members were asked to give their clinical interpretations (See Appendix J for the Focus Group Discussion Guide). Quotes from the interviews were then shared to illustrate themes and therapists were asked to answer questions regarding the clinical interpretation of each theme. Therapists described how the themes might be applied to work in a therapy context. Questions regarding the processes of couple interaction were asked, and group participants shared their systemic impressions regarding the themes from the data.

Serving as focus group moderator, I took notes on major themes that arose during the group process (Piercy & Nickerson, 1996). In addition, the focus group was audio recorded and transcribed, in preparation for data analysis.

### *Data Analysis*

A general qualitative approach was used in the current study to organize, analyze, and interpret themes and patterns from the available data sources. The QSR N6 computer software was used to help organize and code the interview transcripts and to support systematic data analysis procedures. Constant comparative analysis was used to inform each interview from previous findings (Gilgun, Daly, & Handel, 1992). The content of what the couples reported was analyzed, as were couple interaction processes that occurred during the interview.

Data analysis went beyond description of the findings. Categories and themes were also analyzed in comparison one with another (Merriam, 1998). The analysis process was ongoing and integrative. Interviews continued until there was a “saturation of categories” (Merriam, 1998). In addition to the interviews, a research journal containing field notes was integrated into the data analysis procedures. I emerged myself in the data by reading, rereading, and listening to the transcripts and journal. Data from the focus group were examined using a similar process. Through the focus group, the researcher inductively derived “understanding based on the discussion as opposed to testing or confirming a preconceived hypothesis or theory” (Krueger, 1994, p. 20).

In the current study, after the first five interviews were transcribed, I began analyzing the data. The basic coding procedure involved many steps, which are summarized below.

**Step 1: Reading and listening to couple interviews and focus group.** Initially, each interview was read or listened to, to gain an overall perspective of what was said by the participants. Preliminary themes and categories were noted during this process.

**Step 2: Re-reading of interviews, coding the interviews, identifying major themes, and grouping categories of themes.** Once the interview transcripts were imported into the QSR N6 software, they were read again and themes were coded. In other words, sections of interviews relating to specific themes were taken out of the interview and placed into categories with related data units (categories are called “nodes” in the QSR software). Each category (node) was then printed and re-read to identify salient themes within those categories. Salience was determined either through multiple expressions by one couple, through strong expressions made by one or few participants,

or through expressions by multiple couples. Quotes that illustrated these themes were chosen to be included in the manuscript.

Categories were also read in comparison with each other and examined in relation to the theoretical framework and research questions of this study. Specifically, categories of data describing meaning were examined in relation to those describing resilience by exploring the connections that couples made between meaning and adaptation to the hearing loss. Following the analysis of the first five interviews, additional interviews were coded in succession. While no new categories were found in the latter three interviews, additional themes within categories were included in the findings.

**Step 3: Organized descriptions of data were presented to the focus group.**

Once themes were organized according to the theoretical framework of the study they were presented to the focus group. The focus group was initially proposed with the intent to examine resilience processes. However, as vignettes and quotes were shared, the focus group participants expanded beyond resilience to discuss potential problems that couples may face and strategies for intervention with these potential problems. Once transcribed, the focus group was listened to and read to identify and organize themes and categories of themes.

**Step 4: Integration of journal entries and informal discussions.** Journal entries were read and important themes were identified. The journal entries often contained reflections on couple processes and on the connections between meaning and resilience. Because of this, the journal entries provided direction for the organization of themes. Additionally, the researcher had several informal conversations with persons who were hard of hearing that provided insight into the data. For example, while traveling in an

airplane I was seated next to a gentleman wearing a hearing aid. His wife was next to him. During the course of the flight I shared my findings. This couple confirmed much of what I shared and also reflected on the organization of the categories related to meaning. They suggested that positive expressions of meaning followed acceptance and understanding of the hearing loss. Thus, the journal entries and outside conversations were a source of data triangulation for this study, as they supported the themes identified through the couple interviews.

**Step 5: Member checks.** A two-to-three page summary of each interview was made and then sent to the research participants to give them a chance to respond to how their interview was interpreted. Summaries were either sent through E-mail or through the U.S. postal services. Of the eight couples that were interviewed, two returned emails with comments, one returned a letter through the U.S. mail, and a fourth couple was spoken with by phone. While no new themes were identified through this process, findings were confirmed and important themes emphasized.

*Credibility, trustworthiness, and transferability.* Deliberate steps were taken in the research process in order to address the issues of credibility, trustworthiness, and transferability. These processes strengthen the quality and rigor of qualitative research studies (Anfara, Brown, and Mangione, 2002; Merriam, 1998). These steps, including triangulation of data sources, researcher reflexivity, and member checking of data, are organized in Table 3. The triangulation of data included the following: Data were gathered from couples, individual spouses, audiograms, marital satisfaction scores, a focus group, and field journal entries. Member checks were also performed in order to

strengthen the probability that I reported what the participants confirmed was their experience.

Table 3. Methods of improving credibility, trustworthiness, and transferability.

<b>Credibility: How readers can know if the results are consistent with the data collected.</b>	<b>Trustworthiness: How readers can know that the researcher’s findings can be trusted.</b>	<b>Transferability: How readers can know if the study’s findings might relate to the circumstances of others.</b>
Triangulation of data Couple interview data Individual interview data Field notes Marital satisfaction scores Audiograms Focus group findings	Triangulation of data Couple interview data Individual interview data Field notes Marital satisfaction scores Audiograms Focus group findings	Triangulation of data Couple interview data Individual interview data Field notes Marital satisfaction scores Audiograms Focus group findings
Member checking Letters and E-mail messages sent to research participants summarizing results from their interview.	Researcher reflexivity Sections in the Introduction and Findings sections	

## CHAPTER IV

*Findings**Stories of Hearing Loss: The Context of the Study*

In order to provide a context in which to couch the findings of this study, a profile of one couple will be shared (additional profiles can be found in Appendix K). Each couple had a unique way of interacting, which is often identified in family therapy as their "dance" (Elliott, 1992; Watanabe-Hammond, 1990). While very different in many ways, they each described the significance and non-significance of the hearing loss. They also exhibited great relationship strengths and resources. As evident in the data, each couples' adjustment to the hearing impairment became an interwoven thread within the tapestry of their relationships.

*The Gardners.* I contacted the Gardners (a pseudonym) by phone prior to interviewing them. They agreed to participate in the study. The hard-of-hearing husband, Jerry, answered the phone and asked to have his wife (Amanda) get on the line to coordinate schedules. I had not realized that Jerry had stayed on the phone until almost the end of the conversation when he made a comment. I wondered if Amanda did a lot of the talking for Jerry in their relationship.

I arrived at the Gardner's home at about 9:30AM on a clear day that was cool and sunny. The house appeared to have been built in the early 1980s, and the yard was mixed with overgrown shrubs and a couple of rusty iron pieces of abstract art. Two cars were parked in the drive way; one was an old car that looked to be a model that came out in the 1970s, and the other one appeared to be a model built in at least the 1990s. Inside of the house, the walls were covered with beautiful artwork. The contrast between the old and

the new in the surroundings appeared to parallel some aspects of the couple relationship. In some ways their relationship appeared to be based on traditional values, yet in other ways they were very open to exploring what was unknown to them.

I was greeted warmly by Jerry, who escorted me into the living room. Amanda then came upstairs into the same room, letting in two large, friendly dogs from the back porch area. Jerry, a 75-year-old college professor, had taught at a university for many years, and was still teaching. He shared several experiences throughout his life that may have led to a hearing loss.

Amanda was born in 1929. She and Jerry married in 1954, and they had raised two children together. Amanda was educated to be an elementary school teacher, and had worked as a stay-at-home mother and housewife after the first child was born. She first noticed Jerry's hearing loss when he did not respond to something she had said. He just looked at her as if he did not understand what she was saying to him. Jerry reported that he had many ear infections as a child, and that after going hunting his ears rang for a few days. In addition to the hearing loss, both Amanda and Jerry reported having experienced multiple health conditions throughout their lives. They attributed their couple resilience to all of these experiences, including the hearing loss.

To my surprise, and different from what my experience was with this couple on the phone, Jerry spoke first most of the time and it seemed that he spoke more than anyone else during the interview. He seemed pleased that someone would be interested to hear his story. Jerry reported being able to understand his loss because his father had acquired a hearing loss in later life. Jerry had struggled with some depression when he first lost his hearing, but had come to accept his loss over the years. Jerry and Amanda do

not go out as much as they used to, but they still enjoy company in small group settings. Amanda sometimes repeats things in public when Jerry has not heard a question or comment. She is continually on the look out for him in group situations, making sure he is aware of comments made to him or questions asked. Jerry had lost some hearing in his right ear when he was young. His hearing had continued to deteriorate, but he could still function fairly well for a long time because his left ear had a normal hearing sensitivity. They reported that the most difficult part of the hearing loss was the sudden loss in Jerry's left ear, in addition to his gradual loss in the right ear. Thus, Jerry's better ear became deaf, and his poorer ear became his better ear. At this time Jerry sought out some assistive listening devices.

The couple interviews took place within contexts similar to the one described above. While it is construed through my own biased lens, the history and environment of the participants' lives, as presented, reflects the perspectives of these couples.

#### *Findings from All Interviews*

Several noteworthy findings were examined within the data-rich interviews that were conducted for this inquiry. Themes related to the meaning of hearing loss will first be presented, followed by illustrations of resilience processes relating to hearing loss. Couple processes observed during the interviews will then be described. The last section includes findings from the focus group.

#### *Making Meaning of Hearing Loss (What meaning do couples give to their experience of one spouse acquiring a hearing impairment in adulthood?)*

During each interview, couples were asked how they made sense of the hearing loss and what meaning they gave to their experiences. Themes related to meaning

included the process of coming to an understanding and acceptance of the hearing loss, and the belief systems that developed as these processes unfolded.

*Understanding and acceptance.* Several couples described elements of the acceptance process in relation to the limitations associated with a hearing loss. Some admitted to denying the hearing loss, while others came to accept it and then were able to focus efforts on other areas of their lives. One woman (Stacey Johnson - W\*) reported, “When I became conscious of it [her hearing loss] I kept trying to deny. I mean I did deny it by saying, ‘that person certainly doesn’t speak distinctly.’ [laugh] And so I am vague about when I began experiencing a hearing loss.” This same woman said later in the interview, “I am no longer ashamed of my hearing. The shame may be too strong a word. It wasn’t shame as much as vain.” Another participant (Jerry Gardner – H) spoke of the denial he had seen in others with a hearing loss. He said, “A lot of people don’t admit they have a hearing loss. ‘If you would quit mumbling I would understand you.’ Well, that’s not the point . . .” It seems that many who experience a gradual hearing loss make efforts to deny or cover-up any weakness associated with their hearing.

Using Patterson and Garwick’s (1994) three levels of meaning, it could be that couples in the pre-acceptance stage might not (a) perceive the demands as being greater than their capacity, (b) view their relationship as having a communication handicap, and (c) include the reality of living with a hearing loss in their world view. As the hearing loss becomes more apparent, couples may adjust successfully or their coping skills may no longer compensate sufficiently. The adjustment processes influence the meaning of a hearing loss.

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\* Pseudonym is given for the spouse or couple who is speaking and a “W” or “H” is given to indicate whether a wife or husband has the hearing loss.

At some point in time, many do come to an acceptance of their loss and seem able to begin focusing their energies on other areas of life. For example, one couple (Akers – W) said the following:

H: It hasn't held her back. She goes on and does whatever it takes to get through life. I am sure she gets frustrated sometimes. Especially with the telephone because we all like to chit-chat on the phone. And she can't do that.

W: Well, it is a loss for me. But I had to learn to accept it.

At the couple level, others described coming to an acceptance of the social limitations placed on them as a result of the hearing loss. One couple (Gardner – H) described their experience as the following:

W: We managed by altering our lifestyle.

H: We don't go to plays where there is a lot of dialogue. Because I just [don't] know what is going on.

W: But we still do concerts. . . . We get permission to sit on the front row. Right up there and I think we are both rather introverted people and so getting up and going to big affairs...

H: Parties and stuff, I haven't missed that at all.

W: We don't enjoy that. In fact the last one we went to was a cook out, and it was out in the open and there were people there and he had a time. We came back home and the next day he said, "I am so tired, I feel terrible." We didn't do all that much, but he had been under so much stress that he

felt exhausted the next day. It takes a lot out of him. . . . So we have just gradually eliminated all the things that cause him a lot of stress.

H: And she doesn't mind because she doesn't want to go either.

Some couples in this study had similar discussions as this one, while other couples desired to increase their social outings slightly. In summary, both denial and acceptance of limitations seem to be key aspects of the meaning associated with hearing loss.

Almost invariably, couples expressed coming to an understanding of the hearing loss and its effects on their relationship, in part by knowing the etiology of the hearing loss. Some couples expressed comfort in knowing the cause of their own or their partner's loss, (e.g., exposure to loud noise, illness, or congenital hearing loss. For example, one woman (Melanie Stephenson – W) said,

I don't know all the reasons. It could be genetic. This is a left ear thing in my family and yet I am not going to ascribe it to that right away. What I do know is that I have been diagnosed with Meniere's disease. So it is not so much only hearing loss. It is all the noises that compete. And I'm just at a medium level today where it is swishing and making funny little sounds in there. I am used to it now. I don't like it. But for the most part it's one of those things you contend with when it's chronic.

Similar to those who found meaning by knowing the cause of their loss, some couples expressed an understanding of their situation by attributing the hearing loss to normal aging processes. One spouse (Stacey Johnson - W) commented,

It is kind of like your eyesight. You know . . . everyone as they eventually get older have to go to a doctor and have glasses. I just think it is one of those things

with aging that happens to you. . . . How can you make sense of a hearing loss? I just figure that is something that I have. A lot of people have it. As you get older you have a lot of things.

This woman's husband responded by saying, "You have to realize that you are not going to be the same when you are older. And I accept that."

In another case (Hugh Daines – H), despite knowing the cause of the loss, the participant argued that there was no "meaning" behind his hearing loss. It had just happened, and he was left to deal with it. For this couple, efforts to adjust to the hearing loss were directed more specifically toward living with the loss, rather than understanding it. This explanation, that a hearing loss (or other physical infirmity) in later life is somewhat expected, fits with the finding by Sharlin (2000) that long-term couples expect to encounter difficulties and have a mutual understanding that they will stay together no matter what.

**Assertion: Some couples adjust to a hearing loss by avoiding over analysis, and instead, accepting it and accommodating accordingly.**

*Expressions of beliefs and values.* In addition to couples searching for explanatory understanding and acceptance of one partner's hearing loss, they also shared ideas that illustrated the beliefs and values underlying how the hearing loss was integrated into the total picture of their lives. Couples expressed gratitude for and an optimistic view of their current circumstances. They integrated humor into their lives relating to their hearing loss, and expressed the importance of experiencing pleasure through hearing. Through these expressions, the couples in this study shared multiple facets of meaning regarding their experiences.

Expressions of gratitude and optimism by the couples in this study provided insight into the beliefs they held about having a hearing loss. One hard-of-hearing spouse stated, “I am thankful that I am not really deaf. I am thankful and glad that I was able to hear with a hearing aid. That’s all I can say. I am grateful...” Many of the couples also expressed gratitude for not having problems more serious than a hearing loss. One couple (Gardner-H) stated,

H: I am still very active. A lot of friends my age can hardly walk. And there are other things worse. I feel like in a way I am lucky.

W: He went on a 14 to 15 mile bicycle ride. He came back and had family [over] for supper.

For the most part, couples preferred viewing their circumstances optimistically rather than pessimistically. One hearing impaired spouse declared that he had enjoyed every step of the way by looking at the good side of things.

**Assertion: Some couples adjust by seeing positive aspects of life despite being in the midst of hearing loss.**

These examples are a few of the many comments that couples made that minimized the difficulties associated with hearing loss. Couples also contextualized experiences of loss by discussing their hearing problems in relation to additional hardships faced by themselves, as well as others.

Humor was evident, to some degree, in each of the interviews conducted. Couples used humor in different ways, demonstrating how they felt about the hearing loss. Some comments seemed to flow from a deep resentment of the other spouse’s hearing loss. One respondent (Shawn Stephenson – W) commented, “She’ll just pretend she hasn’t heard

you” (husband was the only one in the room laughing at this point). Another interview discussion (Stephensons – W) revealed this same sarcasm. The discussion went as follows:

- W: It [the hearing loss] isn't something that I really worry about....
- H: It is because of all those rock concerts you used to go to.
- W: (laughs) Something I never did.
- H: (laughs)
- W: Just to make sure the record is perfectly clear. See, I can hear quite well.”
- I: When it is really important.
- H: (laughs) . . . You just hit the nail right on the head. She can hear it if it is important. If she doesn't want to hear it, then she can't. You finally analyzed this whole physical infirmity.

Humor was also used in playful jest, which seemed to lighten conversations. When asked how the hearing loss was expected to influence the marital relationship in the future, one non-impaired spouse responded that he had the divorce proceedings already drawn up (both spouses laughing). The wife quickly labeled this comment as a “cornball” joke.

Couples often shared humorous stories that had happened to themselves or to people they knew with a hearing loss. These stories helped to clarify the meaning that couples placed on their hearing loss. One couple (Stacey and Wally Johnson – W) told the following story:

- W: I am in a bridge club and I noticed sometimes someone would bid and I wouldn't be able to hear it. It was real funny when I got my hearing aid and I was playing bridge, somebody heard I got a hearing aid and said, ‘I

didn't know you were deaf.' I said I wasn't deaf, I just wasn't hearing well.

H: That particular person is more deaf than she is. . .

W: That day we all got a joke, saying, 'What did you bid? What did you bid?' (laughing) They all needed hearing aids, they just didn't want to go and get them. One lady told me, 'I just don't want to have to fool with them. . . . I know I need it, but I don't want to.' You just have to make up your mind. It is not like you are totally deaf. I just wanted to hear what is going on.

This couple seems to place a value on admitting possible benefits derived from using hearing aids. They demonstrate this belief by joking about those around them who have not decided to use assistive listening devices. Additional coping behaviors demonstrated by couples who share this belief could include openly acknowledging the hearing loss to increase the likelihood of being able to hear.

**Assertion: Humor about one's hearing loss can be either a coping mechanism or a reflection of tension. The intent (given and received) seems to indicate the difference in meaning.**

A last expression of values and beliefs associated with hearing loss was related to the ability to experience pleasure through hearing. Pleasure through hearing was expressed in two different ways. First, couples talked about the pleasure of being able to hear again with the use of assistive listening devices. One hard-of-hearing man (Hugh Daines – H) said, "I gave up playing the piano about 15 to 20 years ago and only when I got this recent model [of hearing aid] have I gone back to playing." A non-impaired

spouse (Wally Johnson – W) recounted what happened when the audiologist put the hearing aid in his wife's ear for the first time. He said,

He [the audiologist] put it in her ear and started talking with her. And I could see her smile, and he said, 'I am going to go around the corner and keep talking in the same voice.' So he kept on talking. He walked out of his office and turned the corner and she could hear. Her eyes just lit up and she has never . . . The first thing she does in the morning is put them in. And the last thing she does at night is take them out.

On the other hand, some respondents indicated that they had lost experiences of pleasure when they had to rely upon devices to hear. Several of the research participants talked about not being able to hear the birds like they used to. They also talked about being able to listen to music with only one instrument or one voice. These comments leave room for questions of what the couples may have lost in their relationships that were based on pleasurable sounds. For example, intimate expressions often involve spoken words.

**Assertion: The use of hearing aids is more successful for some people than others, and thus more critical in coping for some than others.**

*Beyond description.* Just as Walsh (1996) argued that belief systems are connected to the way families respond to life difficulties, the couples in this study seemed to base their responses to the hearing loss on their beliefs. When couples found meaning surrounding the hearing loss through a medical diagnosis, they made efforts to understand the illness, its repercussions, and ways to deal with it. When the hearing loss was attributed to aging processes, efforts were often focused on assistive listening devices. And, when no meaning was attached to the hearing loss, a certain value was

placed on just “dealing” with life as it came. Thus, it appears that while most of the couples used assistive listening devices, read materials related to their situations, and endured their situation to some extent, a connection can be made between the meaning of hearing loss and the response to the loss.

In addition, couples suggested that their relationship was strengthened from coming to an understanding of their situation. This understanding provided them with the knowledge to successfully meet the expected difficulties associated with their health problems. In response to dizzy spells that accompany Meniere’s disease, one hard-of-hearing spouse (Gardner – H) said, “Yeah, but now we know how to handle them and he just helps me by giving me space and quiet. It takes about 20 minutes for my head to stop spinning.” Another spouse (Tom Jones – W) compared his situation to what it would be like if he were younger. He said, “We have a pretty good idea of the problem. A young couple may not have adjusted.” Confidence and comfort seemed to come through understanding the situation. In his article discussing sexual intimacy when a spouse has a hearing loss, Reiter (1987) suggested that success is most likely when couples are able to accept, understand, and discuss limitations related to the hearing loss.

Many of these comments were made by individuals, yet it is important to remember that they were made in the presence of their spouses. Unseen smiles were given, heads nodded, and tears dropped in response to these comments. It could be said that the *couples* accepted the hearing loss experienced by one partner. *Couples* searched to understand how the hearing loss came about. *Couples* joked and chided each other about their situation. They were optimistic or pessimistic together, and they experienced pleasure and a loss of pleasure together, as a result of the hearing loss. Typically only one

spouse had a hearing loss, but both searched for meaning and held beliefs about their situation regarding that loss.

*Stressors, Struggle, and Strength: Marital Resilience (What relational adjustments do couples make to promote successful aging and resilience in response to the challenge of hearing loss?)*

Each of the couples interviewed in this study had experienced stressors related to the hearing loss in one partner. In addition, at least one partner in each relationship had experienced other health problems that were at least as stressful, if not more so, than those related to the hearing loss. Specific relationship struggles were observed within each of the couple interviews. Despite the stressors and struggles experienced by these couples, overarching themes of relationship resilience were prevalent in adjusting to one spouse's hearing loss.

*Stressors.* Audiology literature has suggested that individual struggles can be associated with acquiring a hearing loss. For example, O'Neil, Summer, and Shirley (1999) identified a relationship between hearing loss and symptoms such as depression, life dissatisfaction, reduced health, and withdrawal from social activities. Nearly all of the partners with the hearing loss in this study described experiences that supported those symptoms. Likewise, some of the couples in the current study reported minor individual difficulties. For example, one couple (Akers - W) talked about the hearing impaired spouse's loneliness. They said:

H: That is probably the hardest thing she has had to deal with. Not being able to talk with friends or family even. You know, our kids or grandkids, even on the telephone, that has been very difficult. It is still hard.

W: I'm a loner, you see. You see I don't have any friends to talk to or anything.

Other couples mentioned experiences that seemed to reach a clinical level of seriousness. This was usually evident when participants used clinical terms to describe their situation, such as trauma, depression, and anger. One couple (Gardners – H) said:

W: Right after he was having so much trouble and lost the hearing from the surgery in the right ear. . . . That was quite traumatic and he was very, very angry for a few years.

H: And depressed.

W: Angry and depressed. And that was hard. Those few years were hard. A good bit.

H: I don't know if it affected our relationship. We just had to adjust.

W: But the first few years were hard. He just wasn't the same. He was angry a lot. And I guess it would be if somebody had had both legs cut off or arms. I know that people that have a sudden thing happen, they do get angry until they accept [it].

Other stressors reported by couples included dealing with a hearing related illness (e.g., Meniere's disease), not being able to communicate in group settings, not being able to watch movies or TV, being embarrassed in social situations, and having difficulty dealing with batteries and squealing of hearing aids. Again, these stressors were often discussed by couples as affecting both spouses in the relationship. This finding is congruent with the research of Kyle and Wood (1983), whose work suggested that family relationships (in contrast to individual lives) were likely to be strained by a hearing loss.

**Assertion: While some of the stressors related to a hearing loss typically affect individuals, it was clear from the current study that negative repercussions related to the hearing loss were experienced by both spouses within the context of their relationship.**

Health problems unrelated to the hearing loss were reported to have a unique influence in the participants' lives. Specifically, in nearly every interview, couples said that some other health problem had affected their lives as much or more than the hearing loss. Some of the health conditions mentioned by the couples in this study included heart problems, high blood pressure, severe eye problems, cancer, mental illnesses, hip replacements, and neural complications. One spouse (Amanda Gardner – H) commented, "He has been through an awful lot. He had prostate cancer surgery, by-pass surgery, two operations on his ears. In a six-year period." Couples reported the severity, danger, and chronicity of these health issues, and their impact on their relationship. One husband (Wally Johnson – W) stated that between his wife's cancer and the health problems his father faced, "We didn't have a whole lot of time for intimacy." Thus, while the influences of additional health stressors in couples' relationships were not examined in depth in this study, the participants acknowledged their role in the development of their relationship and couple interaction.

**Assertion: Obtaining a history of health problems from couples can be helpful, as any number of health issues can add overlying stressors to the couple relationships.**

*Relationship struggles and resilience.* Specific relationship difficulties tied to the hearing loss became apparent during each of the interviews. Each couple had unique struggles and frustrations, and at the same time each couple exhibited strengths and

resilience. Communication processes seemed to be especially strong for the couples. In addition, multiple resilience resources were reported and demonstrated by the couples who were interviewed.

A list of the specific relationship stressor areas relating to hearing loss can be found in Table 4. The difficulties that couples struggled with the most became apparent throughout each interview, whether or not the couple explicitly identified them. It is interesting to note that all of the relationship stressors illustrate problems of couple communication. When this theme is viewed in isolation it might seem that the couples have problems communicating with each other. However, demonstrations of resilience were revealed through the qualitative analysis of these relationship struggles. As exemplified by one couple (Poresky – W):

I: What lessons have you learned from the hearing loss in your relationship?

W: Would you repeat that?

H: That's the lesson!

W: [No comment, with a confused look]

I: What lessons have you learned?

W: You mean between us?

I: Yes.

W: Well, I guess to be more tolerant is the big one.

H: I mean, that is the lesson. When you asked the question, "Would you repeat that?" Well, that's it. That question in some sense draws you closer together.

As in this case, the strength is sometimes found in the midst of the struggle.

It was also found that when the couples were discussing their communication problems in the interviews, they were often carrying on a conversation with one another. For example, one couple (Stephenson – W) took turns expressing their points of view regarding their struggle:

H: I have a couple of things. If she doesn't quite hear something sometimes . . . I can't always hear whether she has heard. And I would much prefer being told, "Could you say that again. I couldn't hear what you said." And my response must then be, to say it more clearly, and not to yell.

W: And I am at fault sometimes at not answering right away. Because I don't know what I have heard and I am hoping he will say it again without me asking him to say it again. Or, I am trying to really run my recorder and "What did I hear?" And so I am hesitating and there's a pause and it is long enough that he is wondering if I have heard anything at all.

H: Lots of times...

W: That happens quite a lot.

H: Lots of times it is useful if you tell somebody something and they say, "OK." Rather than no response.

The competence that couples demonstrated in discussing areas of potential conflict peacefully supports the work by Carstensen, Gottman, and Levinson (1995), who found that later life couples tended to be more affectionate and to express less emotional negativity than their younger counterparts. While the current study did not include a younger comparison group, this finding suggests that some couples in long-term

relationships have learned to communicate with less conflict about problem areas in their relationship.

Table 4. Hearing-Related Relationship Stressor Areas for Each Couple in the Current Study.

- 
1. Difficulty in communicating while driving (hearing impaired spouse cannot hear over the car noises, and non-impaired spouse cannot drive and talk simultaneously) (Gardner).
  2. Problems when one spouse switches subjects when talking with the hearing-impaired spouse on the phone (Akers).
  3. Hearing-impaired spouse sometimes cannot hear what is said, and does not respond (either trying to figure out what was said or hoping partner will repeat without being asked) (Stephenson).
  4. Embarrassment in social situations when hearing-impaired spouse makes irrelevant comments or answers questions that were not asked (Johnson).
  5. When non-impaired spouse talks to hearing-impaired spouse from a different room, it is not clear whether the hearing-impaired spouse heard what was said or if the message was purposefully ignored (Jones).
  6. Hearing-impaired spouse becomes annoyed when his partner speaks too loudly. The normal-hearing spouse says that when she gets excited she tends to raise her voice unintentionally (Daines).
  7. The hearing-impaired spouse feels left out of conversations between her husband and their son at the dinner table. It is especially difficult for her to follow the conversation because she uses some lip reading to assist in conversations, and sometimes the spouse and son make little effort to face her when speaking (Poresky).
  8. The non-impaired spouse gets frustrated when her husband does not hear all that she tells him. She usually attempts to get his attention before speaking but sometimes omits this. The husband has the tendency to be thinking of what he will say next, rather than focusing on what his wife is saying. This was evidenced by his numerous interruptions while she was speaking during the interview (Green).
- 

In addition to couples communicating well about their struggles, they demonstrated and reported confidence in their communication skills. Couples often

described the nonverbal communications they used with each other, such as “a touch on the knee and a touch on the elbow.” One spouse (Akers - W) commented to the other, “Don’t you think that communicating is the best part of the marriage.” Often, couples demonstrated communication competence by (a) sensing when I, the interviewer, wanted to ask another question, (b) listening carefully to the person speaking, and (c) waiting until the person speaking finished sharing an idea. These examples illustrate the confidence that couples can develop in their communications despite a hearing loss.

**Assertion: When one partner in a couple relationship acquires a hearing loss there is typically difficulty in at least some aspect of communication. At the same time, because of the necessary emphasis on communicating, these couples may become effective communicators in other ways.**

Discussions of family coping, adaptation, and resilience have shown that often those who demonstrate a capacity to rebound when faced with stressful situations are those with access to community resources (McCubbin, Balling, Possin, Friedrich, & Bryne, 2002). Specific resilience resources discussed by the couples in this study included having models of resilience and learning from others’ mistakes, utilizing technologically advanced assistive listening devices, and deriving strength through spirituality.

Linked to the genetic etiology of hearing loss, couples in this study often reported that a parent, grandparent, or older sibling had developed a hearing loss at some time. Also, given that hearing loss is more prevalent in later life, participants often mentioned having friends and neighbors with a hearing loss. These friends, family members, and acquaintances served as models for the participants in this study in both positive and

negative ways. One participant described how a sister had gotten a hearing aid that had been very helpful at first. However, the sister had never had it adjusted or maintained, which resulted in an unhelpful hearing instrument. Others described how they would never have made the decision to purchase expensive hearing aids without having heard a positive experience from someone else that they trusted. In addition to having positive examples, these couples often expressed that their own successful adaptation to the hearing loss had influenced people around them to seek out positive ways of coping.

Many of the hard-of-hearing adults that I interviewed used hearing aids or other assistive listening devices. Some of the less typical technological advances that they used included closed caption for TV and movies, TDD telephones, telephones with a volume control, and transmitter equipment with headphones in theaters. In addition to using these devices, several research participants took speechreading courses or made special efforts to learn speechreading skills.

Previous research findings suggested that assistive listening devices positively influenced people's attitudes towards the hearing loss and enhanced their ability to use coping strategies (Backenroth & Ahlner, 2000). Conjunctively, assistive listening resources were reported by participants in the current study to be extremely helpful within their couple relationships. One spouse (Stacey Johnson – W) said, "I would think that the hearing aids have been just as much a blessing to him as they have been to me." Others went so far as to say that getting the hearing aids had been more helpful to their relationship than any other adjustment the couple had made. These comments illustrate the systemic benefit of technological advances in family relationships.

Another demonstration of relationship resources closely linked to assistive devices is the support that non-impaired spouses gave to their hard-of-hearing spouses in seeking professional audiological assistance. Couples discussed the delicate balance of being supportive of their spouse in using hearing aids, yet not being overbearing about it. One participant (Louise Jones – W) actually received advice from an audiologist suggesting that she not “pressure him [her husband] into coming to see me.” This caution was balanced with supportive encouragement. The ability of the couples interviewed in this study to demonstrate supportiveness without pushing their partners illustrates the relationship resilience of these couples.

When asked if and how spirituality played a role in couples’ adjustment to the hearing loss, participants reported that their faith in a Supreme Being helped them to accept the hearing loss and to deal with the resultant difficulties. Both the hearing and the hearing-impaired spouses related the support they received through their faith and through prayer. When asked what she did when times got tough, one participant (Akers – W) replied, “I pray.” The husband then responded, “We do that, and then we sit and talk things over and discuss them.” Another spouse (Wally Johnson – W) said, “I don’t pray for her to be healed, I pray for her to be comforted.” Other statements that illustrated the resource of spirituality included, “If you have faith that things will work out” and “God will help us deal with these.”

**Assertion: Couples access support for resilience through seeing others who are resilient, using hearing instruments, assistive listening devices, communication management, and finding comfort and meaning in their faith.**

*Illustrations of resilience processes through couple interaction.* In qualitative research, the investigator becomes the tool or instrument through which data are gathered. The data are filtered through the investigator's experience and understanding. The filter created by my training in marriage and family therapy became apparent to me during the interviews of this study when I began to differentiate between the content and process of the couples' interaction. The content of the interviews included the themes that the couples talked about, and the process of their relationship reflected the themes that they acted out. Couples also described past couple processes retrospectively when they were asked about changes in their relationship before, during, and after the hearing loss was acquired. Lastly, audiogram reports and marital satisfaction scores also reinforced the strain and strength evident in these couple relationships.

Couple processes or the relationship "dances" that played out during this study further established aspects of marital resilience in response to the adversity of a hearing loss. Themes of relationship resilience that couples enacted during interviews and discussed in retrospect included processes related to spousal caregiving, the re-balancing of emotional ledgers, and the development of marital relationships over time. While less healthy couple processes were also evident during the interviews, this discussion will primarily focus on those that evidenced resilience.

As expected, couples acted out and discussed processes of spousal caregiving in response to one spouse's hearing loss. Interestingly, the hearing spouses often performed most of the extra-marital communications. They were the ones who typically spoke with me on the phone to make arrangements for the interview. They usually answered the door to greet me when I visited their homes, and they often repeated and interpreted my

questions to the hearing-impaired spouse. Also, I was asked to sit next to the “good” ear of the hearing-impaired spouse (often by the non-impaired spouse).

Couples spoke freely about the dependence and interdependence they felt in their relationships. One spouse (Alice Akers - W) said, “I depend on him for everything. I can’t do anything without him. I would be lost without him. I wouldn’t know what to do with myself.” Another hearing-impaired spouse (Melanie Stephenson – W) commented, “I have become even more dependent on him. . . . We are interdependent sometimes to a frightening degree, and I realize that.” These comments and the caregiving nature of the couple relationships in this study confirm the wisdom in conducting this study with couples rather than individual spouses. It seems that the couples’ interdependence was acknowledged through the research process by making couples the unit of analysis.

Couples also expressed evidence of caregiver responsibilities through their activities with one another. Non-impaired spouses reported that they often acted as hearing aid assistants, interpreters in group settings, alarm clocks, and “scout[s].” One spouse (Amanda Gardner – H) said, “I am like a scout . . . looking ahead or watching him to see whether he is aware of what is going on . . . because I know he won’t be able to grasp some situations that are verbal.” Another couple (Gardner – H) acknowledged the difficulty of balancing caregiving with autonomy. They shared:

W: I don’t mother him as much. When this first happened it was like dealing with a handicapped person. I was tending to mother him. He would say, ‘Don’t mother me.’ And, I guess I don’t do that [anymore].

H: No.

I: So you had to adjust and balance the independence?

W: Yeah.

I: (To husband) You wanted to do everything you could on your own?

W: I am not struggling to help him.

H: She understands my limitations better, I guess.

The ability of couples to help one another while fostering the independence of the hearing-impaired spouse demonstrates characteristics of a healthy caregiving relationship.

Literature related to the caregiving of older adults often stresses the importance of fostering control and autonomy in the person being cared for. It also acknowledges that health problems can lead to imbalance, disequilibrium, and change in couple relationships (Dwyer, 1994). Beckham and Giordano (1986) stated that imbalanced caregiver relationships could result in anger and hurt, and if not alleviated, could eventually lead to abuse. The couples in the current study demonstrated an encouragement of individual independence for the partner with a hearing loss. It would be interesting to learn the caregiver dynamics of the couples who refused to participate in this study because they did not feel they had adjusted well to the hearing loss.

It is interesting to note that the literature related to caregiving and couple relationships is mainly focused on situations where activities of daily living are provided by the healthy spouse. The level of care given by spouses discussed in this literature is often far beyond that given when one spouse has a hearing loss. Future research could examine differences between caregiving spouses who perform necessary functions of daily living and those who act more as supports.

**Assertion: Non-impaired spouses often perform caregiver roles and it is sometimes difficult for couples to keep a healthy balance between support and autonomy.**

The second relationship theme that emerged in the interviews was the re-balancing of emotional ledgers between spouses. This theme was frequently played out when a comment was made that devalued one spouse or put one spouse above the other. Negative comments often were made in jest and then later during the interview, a re-balancing attempt was made. This type of interaction can be illustrated by the example given in Table 5. It was interesting to note that most of the re-balancing occurred in response to some joking about the limitations associated with a hearing loss. It seemed as if the non-impaired spouses sometimes responded to the hearing loss with humor that echoed common societal stereotypes of hard-of-hearing persons. Jokes were made about the benefit of not hearing the non-impaired spouse snore at night and about the hearing-impaired spouse selectively filtering out “inconvenient” sounds or requests. Yet, those with the hearing loss vehemently defended themselves by stating that not hearing the snoring was a miniscule benefit in comparison to their losses, and that they never pretended to not hear something (although they may have chosen to ignore something – as all people do sometimes).

Table 5. An Illustration of Re-balancing the Emotional Ledger During an Interview.

(Stephenson) Wife joking with husband:	W: The poor fellow has suffered. Not just the last four years, but for all of our marriage, by me telling him that he has this groveling monotone voice and would he please clear his throat and enunciate.
Husband joking of a time the wife was in pain:	W: The host was on the floor and (wife had a dizzy spell). H: Looking back at it, it was pretty funny. W: Well, maybe he thinks so, I don't think so. H: Well, as soon as I realized what the score was, W: Yah. H: It wasn't something catastrophic, it was a little unfortunate, but There were some funny things that happened.
Husband joking about the hearing loss:	H: It [wife's hearing loss] is because of all those rock concerts you used to go to. W: (laughing) Something I never did. H: (laughs) W: Just to make sure the record perfectly clear. See I can hear quite well. I: When it is really important. H: (laughing) That's just what... You just hit the nail right on the head. She can hear it if it is important. If she doesn't want to hear it, then she can't. You finally analyzed this whole physical infirmity. W: (not laughing) Now, he is joking.
Attempt by husband to re- balance by explaining that he would not joke with wife if they did not love each other:	H: When you understand the leaps and bounds and you know that it's in fun and things are ok . . . I realized this a long time ago when I was in the Army, if you knew a guy really well you could cuss him out. If you didn't know a guy very well, you'd better be careful about how you talk to him. . . . You know there is that relationship, you can deal with people that you know and like and that know that you're . . . in a way you are kidding. W: Yah, well sure, we tease those that we love. H: You just have to know how far you can go when you tease someone.
Re-balance by wife:	W: I'm a very lucky woman, I mean. This is easy. And, sometimes we almost sound too gushy.
Rebalance by husband:	H: You have to understand that my wife is a very powerful personality and a very powerful person because she is very intelligent and she has some awesome talent. And she doesn't always recognize this, but it is true. She is not always easy to deal with, but she cares about a lot of things and a lot of people. And you mix that with sensitivity. . .

**Assertion: Couples may express negative feelings related to the hearing loss through sarcasm or stereotypical statements, yet those with a healthy relationship foundation will often balance these comments with caring expressions.**

The third theme of couple interaction evidencing resilience processes was the development of couple relationships. Couples described the development of their relationships dating from before the hearing loss was acquired until the present time. They discussed how they had grown together in spite of challenges, how their social interactions had changed with the hearing loss and with time, how their confidence in couple communication had grown, and how they did not believe the hearing loss had significantly influenced the growth of their relationship. Couples shared metaphors that described their relationship in connection with the hearing loss, and the growth that had occurred in response to adversity, and they demonstrated resilience through sustained gains in their relationship.

To better understand the context of each couples' experiences with one partners' hearing loss, they were asked to tell how it was acquired, how they began to interact with hearing specialists, and how they interpreted their experiences. Couples gave a marital history of sorts, describing the events that occurred in their relationship with regards to the hearing loss. One couple (Akers – W) reminisced:

H: Our devotion to each other is much stronger than it was when we first started out 40 years ago. And it gets stronger. And I think difficulties, even her hearing problem, or other difficulties makes your devotion, if you really love each other . . . it really makes your love deeper and stronger. Draws you closer together. Of course that goes along with your spiritual

beliefs too. I'm not a fanatic. But we are Christian and we do love each other, and we trust in our spiritual relationship with God.

W: But I don't think it happened until the children left. I think, when it happens after your children leave, you have more time to spend with each other, so that's when it started.

This couple was not the only one to report the positive impact of post-retirement couple time on their relationship. Others commented that because of retirement they had time to care for one another in their physical infirmities.

Other couples emphasized the social changes in their relationship. Some reported slow decreases in social activities partially due to the hearing loss, and partially due to their changing needs to be active in many social gatherings. One couple (Stephenson – W) summarized these two points well when they said:

H: As far as the hearing is concerned, you know it has influenced our personal lives and our social lives incrementally, not in major ways.

W: And, so we have just changed our emphasis. There are things that we don't do much anymore and other things that we do . . . . I mean it is just an aging thing and I think it is important to change and adapt.

Couples described how they were communicating more confidently now and with less conflict, and that they expected their relationships either to stay the same or get better in the future. Since getting hearing aids, one wife (Stacey Johnson – W) commented, “I certainly feel that the relationship is better because I don't feel like I am answering things that he didn't ask.” Another participant (Melanie Stephenson – W) stated, “We simply don't have as much to argue about as we used to. (Laughing) We are not raising those

children anymore.” Again, developmental family processes seem to be influencing the development of the couple relationship. Lastly, in response to a question regarding what the couple relationship had been like since the hearing loss was acquired, the hard-of-hearing husband (Jerry Gardner – H) replied, “Well, it hasn’t changed much.” Similarly, couples often expressed that they didn’t believe the hearing loss would influence their couple relationship in the future. One couple (Stephenson – W) discussed this possibility of the hearing loss getting worse in the future. They said,

W: We will help each other more and more. We will become more and more interdependent and that is what marriage is about.

H: I don’t expect her to become totally deaf. I don’t expect it to change. It may get worse. She may need to have a hearing aid. We will adapt to that. . . . We will work on it. Whatever the problems [are] that come up, we will do our darndest to solve them. What more can you do?

Couples’ experiences of their relationship growing closer, whether due to their efforts to overcome difficulties or as a result of family and life developmental changes, gave hope that they would overcome and enjoy life in the future.

Couples were asked if they could think of a metaphor that would capture their relationship in context of the one spouses’ hearing loss. Several couples struggled to answer this question, yet others shared some insightful images. One couple compared their relationship to a locust sapling. It was described as being young and vibrant, yet with little spines all over it that were prickly in the relationship. Another couple (Akers – W) compared their relationship to a seed. The wife said, “As years [go by] you grow it, your love gets deeper and deeper. At this point right now, we are so deep in love that

we've never shared before. . . . It's like the seed grew stronger." Another couple (Stephenson – W) described their experiences as smoothing off the rough edges. They said:

H: It is like some days the Rocky Mountains will look like the Appalachians. . . . They will be different, but they won't be any less beautiful.

W: Ok, the edges are rubbed off. Polished rock. . . . I have got it right in front of me. There are these rocks I brought back right from Norway and one has been on the shoreline where the granite still has all its crisp edges and another one has been really washed in a really hard driving mountain stream. Well, any old marriage, and I do mean old marriage, gets a little rounded off.

While couples were not always able to verbalize a metaphor of their relationship, they did view and describe their relationships as being strong. One couple (Gardner – H) in which the husband had been through several health problems (including hearing loss) observed:

H: The combination [of illnesses] made us strong. She has had to go through all three of them. In some ways it is probably harder on her. . . . Anything like that will tend to make you stronger. Any kind of adversity.

W: I have been through a lot with him.

The strength and resilience reported by these couples seemed developmental in nature. As Staudinger and associates (1993) discussed, plasticity and reserve capacity are often overlooked traits of later life couple relationships. Thus, as couples mature and grow in their relationships, they may have the ability to change as needed. They may also draw upon a reserve capacity that has built up over the years they have spent together.

**Assertion: Couples view hearing loss as either not affecting the core development of their relationship, or as strengthening it.**

Couples expressed gains in their relationships that were sustained over time. These gains further support the notion of resilience in the couples of this study. Themes of sustained gains included the finding that couples were still very engaged in a number of activities and they helped each other by compensating for one another's physical losses.

Specifically, couples said that when their activities were limited by the hearing loss they chose to focus on other manageable activities. Couples expressed an enjoyment for reading, working (some were retired and doing part-time work, others were still working full time), traveling, going to theater performances and movies, and enjoying family gatherings such as children's weddings. This modification to a couple's activities is a good illustration of the selectivity processes of successful aging, as discussed by Baltes and Baltes (1990). Just as the theory suggests, the couples in this study chose to focus their energy on a selection of their previous activities (or new activities) wherein they could still function successfully.

Very often couples made comments such as the "deaf leading the blind," each spouse bringing "half-a-wit" to the relationship in order to function, and so forth. Spouses were found compensating for each other. One spouse interpreted during an interview, while another spouse read or wrote for the partner. One spouse cooked all the meals, did the laundry, and cleaned the house, while the other dealt with all of the paperwork items. Another non-impaired spouse reported that she encouraged her husband to focus on activities that did not involve as much hearing, such as using the computer, golfing, and

flying model airplanes. Couples roles were often prescribed by the partners' physical limitations. Yet couples joked about this, and seemed grateful that they could help each other out. The word interdependence was used frequently. An example of this can be seen in one participant's (Gardner – H) comments. The wife said:

We laugh sometimes, he has better eyes than I do. With his glasses. I have a problem seeing road signs and so he reads road signs for me if I am driving. . . . When I get so I can no longer walk because I can't see, I'll get a wheel chair and he can push and . . . can see when the light turns or whatever and I can hear the policeman buzzing at us. (laughter) And off we will go.

Thus, couples' resilience processes were exhibited through positive development of couple relationships, descriptions of relationship growth through adversity, and sustained relationship gains. Also, couples showed their resilience to imbalanced emotional relationship ledgers and to caregiver aspects of couple relationships where one spouse has a hearing loss.

**Assertion: Some couples adapt to selective changes that accompany a hearing loss by refocusing their energies in ways that they can still find satisfaction. In addition, in some relationships where both spouses have physical limitations, spouses compensate for each other's losses with their strengths.**

*Marital satisfaction and levels of hearing loss.* The KMS scores for the research participants in this study are shown in Table 6. These scores reflect the high marital satisfaction of the current research participants. They also support the resilience demonstrated by couples in the interviews and through their reports of successful adjustment to the hearing loss.

Table 6. Participants' Kansas Marital Satisfaction Scale<sup>a</sup> Scores by Spouse.

Couple Pseudonyms	Husband's Score	Wife's Score
Akers	21	21 <sup>b</sup>
Stephenson	21	21 <sup>b</sup>
Johnson	21	21 <sup>b</sup>
Jones	21	21 <sup>b</sup>
Gardner	21 <sup>b</sup>	21
Daines	18 <sup>b</sup>	18
Poresky	18	21 <sup>b</sup>
Green	18 <sup>b</sup>	18

<sup>a</sup> Scores reflect responses to three questions, with 21 being the maximum score.

<sup>b</sup> Spouse with the hearing loss.

Note: The range of possible KMS Scale scores is 3 to 21.

The audiogram reports that were described in Table 2 of the Methods chapter showed that four of the hearing impaired spouses had experienced a hearing loss at the “profound” level in at least one ear (in couples number one, two, five, and eight). It is interesting to note that only the last couple interviewed had KMS scores that were lower than the highest score possible. The individual circumstances of these couples aid in understanding the marital satisfaction despite the profound levels of hearing loss in half of the participants. The hearing impaired spouse in the first and last couples both had acquired their initial hearing loss as young children. Although they had significant additional losses in hearing as adults, they both had much more time to adjust to their losses. The hearing impaired participants in the second and fifth couples both had better hearing in one ear, and at least fair speech discrimination. Thus, their ability to communicate with their spouses was better than it would have been if they had had a

profound loss or poor speech discrimination in both ears. Future research examining relationships wherein the hearing loss has reached the profound level, and has been of shorter duration, might reveal that severity and duration play important roles in marital satisfaction.

These descriptions of resilience are supportive of the types of competence discussed by Luthar and colleagues (2000). These types of competence included doing exceptionally well despite adversity, sustaining positive adaptation over time, and recovering well from traumatic experiences. Some couples in this study seemed to respond unexpectedly well despite severe, chronic hearing losses. Some sustained positive adaptation throughout the gradual loss of age-related hearing impairment, and some recovered well from traumatically sudden hearing losses. Thus, while not all couples exhibited resilience in all aspects of their relationship, each showed resilience processes in some way.

*Clinical Protocol with Hearing Impaired Clients (How might marriage and family therapists use or support the adaptive strategies that the participants identify in therapy with clients who experience similar circumstances?)*

The following section describes and expands insightful themes gathered from a focus group with experienced marriage and family therapists. Therapists' responses to themes from the interviews were grouped into three categories: couple dynamics, possible clinical situations with these couples, and the therapist/client relationship. In addition, therapists mentioned that the group discussion was very informative regarding hearing loss and that they would be able to better serve clients with a hearing loss due to

the information shared. Interestingly, therapists' inquiries during the group supported the couple interview data, and acted as a source of triangulation.

*Couple dynamics.* Various clinical insights were shared by the therapists regarding the systemic ramifications of hearing loss in couple relationships. These themes included gender influences, communication processes, and caregiver processes.

Clinicians identified gender influences in couples where one spouse has a hearing loss. The clinicians suggested that men might be more likely to distance themselves emotionally by giving less effort to communicate when presented with ongoing stressors. They suggested that men who take on a macho image might say, "I don't need this. I don't want help. I can make it on my own." From the couple interviews, one couple (Gardner – H) discussed their experience of gender influencing couple communication. They said:

W: A hearing-impaired person [has] to learn to communicate their feelings. I think women are better about that than men are. Men are notorious about not sharing their feelings. He is frustrated. Or at one point he was going to bed at 8:30 because of the trauma of the television noise. . . . If he could communicate, why . . .

H: Communicating is really hard.

**Assertion: Clinicians working with couples should take into account how gender might influence couple interactions and adjustment to a hearing impairment.**

Some themes were identified in relation to couple communication processes in the context of hearing loss. Clinicians observed that with hearing loss, couples may be left to struggle with the most basic of communication processes, and that it might be tiring for

them to constantly struggle at that level. One clinician commented, “Just the irritation and frustration and bothersomeness of it not being as perhaps simple as it used to be. You have to ask yourself, ‘Is it worth this much trouble communicating or should I just sit and stay quiet.’” The systemic repercussion of this scenario is that if one partner develops a tendency to tune out, the couple relationship will be affected. It was suggested that these communication struggles are likely emotionally draining to both spouses, necessitating relational coping mechanisms. In fact, the focus group participants agreed with one clinician, who said that, “individual ways of coping in a couple are actually systemic, because the [unimpaired] partner is always affected by what the other individual does.”

According to symbolic interactionism theory, couple interaction, the roles each spouse carries out, and the life context shape the identity of the couple (LaRossa & Reitzes, 1993). Thus, ongoing responses to hearing-related difficulties can shape the couple relationship for better or worse. The therapists in the focus group seemed to be saying that the communication difficulties related to hearing loss would likely weigh on couple relationships, and influence their development negatively. In contrast, the couples in the current study most often reported that they either did not think the hearing loss had affected their relationship development, or that it had influenced their relationship positively.

**Assertion: According to the focus group clinicians, some couples seeking therapy may have developed unhealthy couple interactions related to the hearing loss, which have negatively influenced the couple relationship identity.**

The delicate processes involved in relational coping mechanisms can be depicted well through caregiving situations. Therapists gave the opinion that it can be difficult for

couples to find a balance in autonomy versus dependence when a health stressor is introduced into couple relationships. It seemed important that couples be in agreement regarding the “satisfaction with the outcomes of caregiving.” Clinicians suggested that when one spouse is over-dependent on the other, imbalances can lead to major difficulties in the relationship. As mentioned earlier, discussions in the literature on spousal caregiving have suggested that imbalances and boundary issues can lead to relationship conflict (Giordano & Giordano, 1983). In summary, it seems that therapists working with couples in caregiving situations should assess (a) the balance of emotional, mental, and physical responsibilities carried by each spouse and (b) the couples’ satisfaction with how the responsibilities are situated.

As a parallel process extending from the couple relationship to the therapeutic relationship, Beckham and Giordano (1986) suggested that therapists be aware of the “balance” of attention they give to each spouse when one has a physical illness. Specifically, they encouraged therapists to overtly reassure the spouse with the disability that they (therapists) are striving to help both partners. In doing this, therapists can model healthy levels of responsibility, autonomy, and independence for their clients.

An example from the current study illustrates this balance. One non-impaired spouse seemed to take full responsibility for conflicts around communication difficulties that occurred. A clinician in the focus group wondered if the couple had agreed upon this balance, or if they had somehow gotten into a pattern of one spouse acting as the “good parent,” and the hearing-impaired spouse as a child – being “diminished somewhat.” It was acknowledged that the care-taking spouse “might have an altruistic or benevolent idea around the caregiver or care-taking responsibility to cause [his wife] not to feel

worse in her loss.” In this situation, it could be important to assess the power differential in the relationship, and to look at the couple’s satisfaction with their arrangement.

Of further clinical interest to caregiving in couple relationships, Van Amber and colleagues (1996) found in the family therapy literature that the most frequently reported presenting problem for older adults who sought psychotherapy was related to spousal caregiving. This finding suggests that therapists would be wise to assess couples for caregiving situations and their possible repercussions, in all couples seeking services when one partner has an impairment.

**Assertion: Once healthy couple relationship processes can be strained with the introduction of health problems and resulting care-taker roles.**

*Possible Clinical Situations.* The family therapists in the focus group were aware that the couples interviewed for the study were adapting well, for the most part, to the hearing loss. In this context, they gave examples of how the couples’ situations could be adapted to a more clinical population. They then offered interventions they might use with hearing-impaired clients. One potential problem they mentioned was the buildup of frustration, anger, and depression from the small alterations in communication routines. A clinician explained, “You wouldn’t think that driving down the road and talking with your spouse is a problem, but it is becoming one.” In situations such as these, the clinicians wondered about the processes of grieving, loss, and acceptance of both spouses. It was suggested that the main goal with such couples might be to help them come to accept their condition by understanding where it came from, allowing couples to move on in their lives.

In connection with acceptance, the therapists considered the course of the illness as playing an important role in how couples adjusted. They wondered about the gradual vs. sudden onset of the hearing loss, and how couples' experiences fit with their life expectations. Rather than focusing on the severity of the hearing loss, clinicians seemed to agree upon the importance of inquiring about the couples' perception of the loss. This suggestion relates directly back to the theoretical model of this study, with attitudes and beliefs influencing adaptation responses. One therapist suggested that a therapeutic way of approaching acceptance would be through couples' narratives of the hearing loss. This suggestion is based on White and Epston's (1990) model of narrative therapy. Simply stated, in the narrative model the negative stories of peoples' lives are deconstructed and then "reauthored" using language that describes life more positively. The focus group clinicians indicated that when acceptance of a hearing loss had not been reached, couples could re-story their narrative to include coming to terms with their situation and moving forward.

In contrast to couples in the current study, therapists noted that some clinical couples may not be able to rebalance the emotional ledger in response to negative comments. Gottman's (1999) idea of the "emotional bank account" was suggested by one clinician as possibly being helpful. In couples where the foundation of an emotional bank account was not well established, Gottman has suggested that couples have stress-reducing conversations on a daily basis, and that they make efforts to "turn towards" each other more often than turning away from each other.

Other interventions were suggested by clinicians in the focus group. Some of these included (a) asking the non-impaired spouse how the hearing loss has influenced

his or her life, (b) creating psychoeducational opportunities around hearing loss issues, (c) focusing on the strengths that couples bring to therapy that have helped them to deal with stressors, and (d) helping couples to make second order changes (i.e., changes that go beyond a mere behavioral modification).

**Assertion: Marriage and family therapists can be equipped with systemic and narrative therapy models, as well as clinical interventions, that may be useful in helping couples that struggle with stressors related to hearing loss.**

*The therapist – client relationship.* Family therapists have identified similar patterns of interaction (parallel processes) between family relationships and client/therapist relationships (Doehrman, 1976; as cited in Todd & Storm, 1997). Parallel to couple adjustments made for individual hearing losses, the therapeutic relationship can be influenced by a client's hearing loss. Clinicians agreed that the hearing loss of a client would likely have an influence on the communication processes in therapy. They suggested that just as partners can become irritated by small communication difficulties, the therapeutic relationship can be jeopardized by the discomfort of making added efforts to communicate. In addition, therapists reported that they sometimes have the tendency to favor communication with a more verbal spouse in couples therapy. Related to hearing loss, therapists may inadvertently favor communication with the non-impaired spouse. In response to this type of situation, one therapist commented,

As a therapist I ask the one who hears better to not be as quick to speak . . . [that] I need to hear this from her or from him (the hearing-impaired spouse) right now. Be very literal about that. It puts them on the spot for a response.

**Assertion: As is often the case in therapy, processes between family members can play out in the therapeutic relationship. Therapists should strive to be aware of how a client's hearing loss could influence the therapeutic relationship and in-session communication processes.**

The themes from the focus group, as examined by the researcher, demonstrated data triangulation with those from the couple interviews. Namely, when presented with a case scenario of a couple with a hearing loss, the therapists were interested in finding out about the process of acceptance for couples and how one spouse's loss influenced the other spouse. Therapists responded to vignettes by pointing out strengths in the couple relationships, affirming the evident resilient couple processes. The discussion of themes from the focus group will further illustrate the overlap between the two sources of data.

### *Conclusion*

In conclusion, couples' reports of their experiences and situations indicated processes related to making meaning of one partner's hearing loss. Participants' beliefs and values surrounding the hearing loss seemed to be linked to their relationship adjustments. Many responses were categorized as demonstrating resilience and strength. Additional couple processes were observed and shared in retrospect, which highlighted relational resilience. Clinical applications of the themes from the couple interviews built upon systemic couple processes and revealed areas for clinical intervention with couples where one spouse has a hearing loss.

## CHAPTER V

*Discussion*

As exemplified in the Findings chapter, results from the current study were supportive of previous research findings and published literature. The research questions were answered through the meaning that couples made of their experiences, the resilience processes that they reported and demonstrated, and the clinical insights shared by focus group clinicians. The findings from this study give direction for future work. Implications seem applicable to family resilience theory, marriage and family therapy practice, audiology practice, and future research. In addition, a discussion of researcher reflexivity is shared.

*Family Resilience Theory*

For the purposes of the current study, resilience was defined as when couples were exposed to a significant risk (hearing loss) and they showed positive adaptation in their relationship despite that risk. Taking into account the researcher model of resilience, a significant level of risk was established (by participants having gone to an audiologist), and successful adaptation was measured (through the marital satisfaction scale). From the practitioner perspective, resilience processes were explored with all of the couples regardless of their level of hearing loss and their reported level of marital satisfaction. Greater emphasis was placed on the exploration of resilience processes within couple relationships than on determining whether a couple had adapted successfully or not. In this sense, each couple in this study demonstrated characteristics of resilience.

In addition to demonstrating exposure to significant risk and the positive adaptation to that risk, resilience was found in both the characteristics of the couples (i.e.,

protective factors), and in the fruits of resilience (i.e., resilient outcomes). In this study, protective factors were related to the strengths evident in couple relationships. Likewise, resilient outcomes were shown through demonstrations of resilience that seemed to result from relationship strengths.

Recent articles were published in special issues of *Family Relations* and the *Journal of Marriage and the Family* that focused on resilience. The authors of the lead articles asked questions for investigators in the field to answer with future research. Answers to some of their questions can be taken from the current study.

First, Ganong and Coleman (2002) stated:

Care is needed in conceptualizing what is meant by risk. . . . A definition of risk that seems to evolve from this collection of papers is that risks are chronic (ongoing mechanisms or factors) and may include developmental issues, gender issues, and structural issues, societal issues, or both. Risks may come in multiples, they may primarily involve one family member or several, and they may initiate outside of the family as well as within. Which of these views of risk can we, as family scholars, accept? If multiple definitions of risk are applicable, do they evoke the same or diverse resilience processes?

From one point of view, the current study included multiple definitions of risk. Both men and women with a hearing loss were interviewed. Developmental issues were relevant because of the increasing likelihood of someone having a hearing loss in later life. Also, only one spouse had a hearing loss in most of the couples from this study. From this perspective, it was interesting to find that both men and women sought to gain understanding and acceptance of hearing loss. The hearing loss was either acquired or

significantly worsened in later life, and only one spouse personally experienced the primary stressor of a hearing loss.

With these differences in mind, the resilience processes described in the current study were still similar across couples. On the other hand, if factors such as gradual *versus* sudden onset of hearing loss, mild *versus* severe loss, older *versus* younger couples, or higher *versus* lower socioeconomic factors were to be included in the same study, it seems that different resilience processes would be explored.

Second, Coleman and Ganong (2002) asked, "Conceptually, what does the construct 'family resilience' add to the 'positive adaptation to stress' literature?" This question addresses the need to acknowledge the important work that has been done in the positive adaptation to stress literature (e.g., Boss, 1987; Hill, 1949; McCubbin & McCubbin, 1996).

In an attempt to integrate these two models, Patterson (2002) argued that "the concepts that underlie it [family resilience theory] are already contained in family stress theory, [however] a focus on resilience draws greater attention to family success and competence" (p. 358). Applying these ideas to the current study, it could be said that all of the couples in the present study exhibited successful adaptation, and some of them described their experiences with hearing loss as being resilient. For example, some said that their relationships were stronger as a result of other health problems they had faced. These couples reported that their relationship was made stronger despite the adversity. The current study supports Patterson's (2002) discussion of these two models, and appeals to her call for qualitative research by describing the meaning making and resilience processes involved in couple relationships where one spouse has a hearing loss.

A debate similar to successful adaptation *versus* resilience has played out in the field of gerontology through the concepts of successful aging *versus* aging well. This debate began as different models of successful aging presented conflicting definitions of what it meant to age well. The Rowe-Kahn (1998) model stressed low risk of disease and disability, high mental and physical functioning, and an active engagement with life. A contrasting model by Baltes and Carstensen (1996) emphasized self-perceptions of successful aging by asking how well one is doing considering his or her situation. A recent pair of articles appeared in *The Gerontologist* (2002), which discussed the current state of the field regarding the integration of “successful aging” and “aging well.” Kahn (2002) commented on the complementary nature of these models. Moreover, he said, “The theoretical integration of these three models is a task for the future. In the meantime, all three are useful as research guides” (p. 726). Relating back to the current study; the integration of successful aging models parallels the possibilities for the family stress and family resilience theories.

Third, Coleman and Ganong (2002) asked, “How does the ‘family resilience’ practitioner address within-family variations in response to adversities and effectiveness of coping strategies?” In the current study, some couples showed within-variation responses to the hearing loss. For example, one spouse seemed to cope with the hearing loss at times by dominating the discussion of most conversations. Privately, the wife of this participant informed me that her husband did not listen well during couple conversations. For the husband in this situation, this coping was adaptive. For the wife, this coping was not successful. It seems from this example that family resilience can not be established unless the processes involved are beneficial to all members of the family.

This differs from individual resiliency, which focuses on individual processes. This question would need to be revisited when the relationships of more than two members are examined.

In addition to answering these questions, the current study seems to move the theoretical framework of couple resilience forward. Specifically, by examining the experiences of couples as the unit of analysis, the development of meaning and belief systems are expanded from individual processes to relational ones. While it may be that Walsh and others have labeled the processes involved in family resilience as relational, there seems to be little research that has examined how a couple came to understand and accept their situation – together. In other words, it seems that the relational construct of meaning has been identified in the literature, yet the relational process of reaching meaning seems underdeveloped at this point in time. Future research could examine this process in greater detail. Therefore, just as Kübler-Ross (1969) has described the process of individual grieving, researchers might be able to identify couple and family processes of working together to understand the resilience processes they go through.

*Marital Satisfaction.* According to the Kansas Marital Satisfaction Scale Scores, all of the research participants reported to be either “Very Satisfied” or “Extremely Satisfied” in their marriage. These high scores seem to reinforce the expressions of relationship resilience despite a hearing loss of one partner. Furthermore, it is interesting to note that all but one couple had congruent satisfaction scores, even though the scales were administered to spouses individually. This compatibility of couples’ scores shows the congruence of spousal perceptions of their relationship. It is also interesting to note that the one couple that reported differing levels of spousal satisfaction was actually the

only couple interviewed who demonstrated physical affection during the interview. At one point in the interview, the couple tenderly held hands while talking about their experiences. Thus, while KMS scores were not the same for both of these spouses (one was 18 and the other was 21), scores for each were relatively high.

Taking the KMS scores and the couple interviews into account, it seems that each of the couples in the current study exhibited a strong marriage relationship, regardless of the severity and duration of the hearing loss. When the different levels of hearing loss and speech discrimination results were examined, it was evident that some of the couples had to adjust to a greater level of loss. In addition, the duration of time since the hearing loss varied. Thus, some couples may have to make more significant relationship changes, depending on the severity and duration of the hearing loss acquired. At the same time, level of hearing loss, by itself, did not seem to be indicative of marital satisfaction for the couples in this study. A few couples, who likely did not have high KMS scores, refused to be interviewed in this study. Their refusal may reflect the marital satisfaction and couple resilience of the current sample. Future studies might explore the relationship between factors of hearing loss and relationship satisfaction in greater detail.

All but one couple in the current study included one spouse that used hearing aids. Each participant that used hearing aids seemed to be satisfied with the aids. Future research might also explore marital satisfaction in relation to satisfaction with hearing aid use.

#### *Implications for Marriage and Family Therapists*

Several ideas from the literature can be helpful for family therapists working with couples in which one spouse is hearing-impaired. Hetu (1993) found that hearing loss

was not associated with marital breakdown, that couples with a hearing loss had a shared problem with unshared solutions, that each spouse needs to be supported in his or her view of the hearing loss, and that audio-rehabilitation should include both partners.

Piercy and Piercy (2002) listed several suggestions for therapists, including ideas related to basic couple communication processes, advantages of assistive listening devices, encouragement for communication balance between therapist and clients, encouragement for clients to be assertive of their hearing-related needs, and encouragement for partners with a hearing loss to seek out support from others in similar circumstances. Below are listed ideas from the current study. These ideas are organized according to the source of data that they came from. Some were derived solely from the focus group, others from my observations during couple interviews, and others are a combination of both.

### **Focus Group Ideas**

- Just as communication processes in couples where one spouse has a hearing loss can be difficult, so to can communication between hearing-impaired clients and their therapist be difficult. Therapists should be aware of the couple dynamics so as to avoid duplicating unhealthy parallel processes in therapy.
- As basic communication processes can deteriorate with a hearing loss, therapists can encourage clients to communicate about their processes of communication.
- Clinicians can include psychoeducation in their work with hearing-impaired clients. They can seek out knowledge on hearing loss or the clients themselves can teach the therapist so that the process of therapy can occur within an informed context.

### **Researcher Observations**

- Just as with any illness or impairment, couple identities can be greatly influenced by a hearing loss. Therapists can make efforts to understand how the thread of hearing loss is woven into the tapestry of the clients' lives.
- By using a “clinical” definition of resilience (Walsh, 1996), therapists can look for and find strengths in every couple relationship where one spouse has a hearing loss.
- By encouraging clients to share the positive and negative examples of adjusting to a hearing loss that they have encountered, therapists can tap into couples' latent resources.
- Whether or not a health history is given at the beginning of therapy, clinicians can benefit greatly by understanding the health problems that couples face.
- When frustrations around hearing loss are expressed by clients, therapists can look for, observe, and even encourage balancing statements (e.g., “But he’s my all time great supporter, interpreter”) that help to define and “balance” couple relationships by according the hearing impaired spouse special respect or recognition of some kind.

### **Combination of Research Observations and Focus Group Ideas**

- Hearing loss may not be identified as the presenting problem, yet if present will most likely play into the relationship of the clients. This was evident in the interviews as more than one couple reported that they did not believe the hearing had impacted their relationship much.
- Given that each couple in this study had some specific communication struggles, therapists should make efforts to identify the hearing-related relationship stressor that affects their clients the most.

- When one spouse has a hearing loss, the other spouse can become a caregiver of sorts. By assessing the balance between autonomy and dependence, therapists can become aware of how couples have adjusted to compensate for the loss.

As the population of older adults increases in the United States, and as older adults are projected to increasingly receive psychotherapy services (Zarit & Knight, 1996), marriage and family therapists can provide informed assistance to their older clients who experience a hearing loss in later life. In addition to these suggestions, marriage and family therapists' systemic training equips them with knowledge about couple relationships that can be invaluable in working with hearing-impaired clients.

#### *Implications for Audiologists*

For audiologists, it seems that the first important theme is that of meeting with both spouses when possible (Hetu et al., 1993). This can apply to initial appointments and also for rehabilitation (Abrahamson, 2001). Audiologists can teach couples about the etiology of the hearing loss, which may help them let go of blame and guilt. Audiologists could teach couples about successful communication strategies, how spouses can be supportive of one another, and how they can adapt in light of the gradual changes (Piercy & Piercy, 2002). They can teach couples about assistive listening devices as well as hearing aids. This might encourage couples to look into technological advances that might ease some of the relationship strains related to the loss. In short, audiologists can provide information that can be helpful for couples with a hearing-impaired spouse, as they learn to live with the hearing loss.

*Directions for Future Research*

The qualitative nature of the present study lays a strong foundation for future research. By first seeking to understand the experiences of hearing loss in couple relationships from couples themselves, the resulting constructs related to their experiences can be taken and applied to larger scale studies. Family relationships in diverse cultural groups, educational levels, and socioeconomic backgrounds of the hearing impaired can be examined. This becomes especially important as the current study focused on an exceptionally elite group of couples. The perceptions of couples who are experiencing relationship distress (possibly not unlike the group of couples who refused to participate in this study) are likely different from those in the current study.

Every couple in this study mentioned health issues other than the hearing loss that were either as difficult or more difficult to adapt to than the hearing loss. It is important to understand individual illnesses and their unique influences on relationships. However, it also seems that to analyze one illness separate from many others that are interconnected could breed misleading results. Thus, future research could examine couple relationships in which multiple chronic health conditions exist. The definition of risk should be expanded, and the processes involved with making meaning and living resiliently should be identified within the complex context of multiple stressors.

Relating to hearing loss, future research should explore couple relationships in early and middle adulthood where one spouse has a hearing loss. Experiences of those who have a sudden *versus* gradual onset of hearing loss with varying levels of severity should be explored, as well as couple relationships where both spouses have severe hearing losses. Due to the uniqueness of the current sample, with all couples reporting

fairly high marital satisfaction, research with couples who are unhappy could lend great insight and allow for contrast and comparison. With the technological advances of cochlear implants, the relationships of couples going from not hearing to hearing also should be explored.

Many people who have inquired about my doctoral research have responded by saying something like, “Oh, really! My father has a hearing loss.” Just as a hearing loss of one spouse affects the other, hearing impairments experienced by grandparents, parents, siblings, and other relatives, influence the lives of their family members. For example, one participant in this study reported that she no longer spoke to her father who lives hundreds of miles away because it was too frustrating to try to talk on the phone. The current study lays the groundwork for exploring such intergenerational relationships influenced by hearing loss.

As mentioned in the findings section, most of the caregiving literature focuses on those relationships where a caregiver assists with activities of daily living or instrumental activities of daily living. Those relationships where care is given to a lesser degree, such as with hearing loss, may involve different couple processes. As discussed in this study, the care given in these situations may branch out into the social realm or to activities involving interpersonal communications that enhance the quality of life. Thus, future research could examine differences between caregiving spouses who perform necessary functions of daily living and those who act more as supports.

### *Researcher Reflections*

Reflexivity has been defined as the researcher’s awareness of how he or she influences the social world of the research participants, and in turn how the research

process influences and is reflected back through the researcher (Rossman & Rallis, 1998).

The next few paragraphs are an extension of the “Role of the Researcher: Personal Reflections” section found in the introduction of this study. That first section described some of my personal experiences and background that are likely to have influenced the research process. This section is used to describe the perceived impact that I had on the research process. It also includes reflections of the impact that the research process has had on me.

*Going into their world.* It has seemed that my personal connection with hearing loss, through the experiences of my family members, has provided a lasting desire to learn about hearing loss and relationships. It has seemed that couples could tell that I cared about their experiences and wanted to learn from them. Sensing my interest has seemed refreshing to the hearing-impaired participants, who said that they did not talk in-depth about their loss often.

My comfort in these couples’ homes and their lives may have been influenced by my previous training in gerontology and research experiences with older adults. I found that similar to working with participants of the VT Adult Day Service, there was a quickly gained trust between myself and the participants. This allowed us to speak freely in the interviews. The trust may have also been influenced by the snowball sampling method, with participants inviting me to come into their homes because a good friend of theirs referred me to them.

Entering the couples’ systems as a newcomer, I was treated with a socially appropriate distance. Participants put their “best foot forward” during the interviews. However, sometimes one spouse would disclose something revealing about his or her

partner that seemed to not typically be shared in social settings. Most often there was a sense of trust between the two spouses, and it seemed that permission was granted to “go there.” My sense of how the couples were feeling with each other throughout the interviews was enhanced by my training in marriage and family therapy. Research participants may or may not have been aware that I sensed their level of comfort. Some interviews flourished under such disclosure, leading couples to self-discovery, whereas others revealed discomfort and introspection by the participants. In the latter case, those couples seemed slightly relieved to see me leave.

My personal optimism seemed to influence the direction of the couple interviews at times. I often reflected positive interpretations of couples’ experiences. Couples seemed to enjoy a positive discussion about a topic that has been painful for each at one point or another.

*Entering my world.* In addition to my influence on the research process, I have been influenced by this study. Regarding my family, I had the opportunity to visit one of my grandfathers during the study. We talked about how his hearing loss came about, how it had progressed throughout the years, and his use of hearing aids. During our conversation, he took out his recently purchased digital (completely in the ear) hearing aid and showed it to me. The outer portion of the hearing aid matched his skin color, while the part that was inserted into the ear was a fluorescent blue – not what I would have expected my grandfather to be wearing! This was a rewarding and bonding interaction between my grandfather and me. My work on a topic of interest to him drew us closer together.

Throughout this study I have become more sensitive to persons with a hearing loss. My discomfort in communicating with hard-of-hearing persons has dissipated as I have learned to speak more slowly and distinctly and to face the person while talking. I have greater sympathy for those with a hearing loss when I speak with them on the phone, and greater empathy for the normal-hearing spouses who forget at times to communicate purposefully. Evidenced by my lengthy conversations with friends and acquaintances about their hearing loss, my comfort with hearing-impaired adults is growing.

I was surprised to find how similar qualitative interviews with couples about a life stressor were to therapy. I was often amazed and pleased to see couples learning so much about their situation by conversing about it with a third party asking questions. At times I was struck by how similar the interviews were to therapy (i.e., couples arguing about something or me asking personal questions). I made efforts not to take sides with one spouse over the other. At times negative couple interactions became apparent, yet I made no attempt to intrude on this process as I was in the role of the researcher and not the clinician.

In summary, my personal and professional experiences had an impact on the research process and the participants' lives. Similarly, my life did not go uninfluenced throughout this inquiry. The discussion of these insights reflects the reflexive nature of this study. This reflexivity becomes another source of data introduced into the analysis.

### *Conclusion*

In conclusion, this exploration of couple interaction processes when one spouse is hearing-impaired provided insights into the meaning attributed to hearing impairment and

the resilience expressed by these couples. Understanding and coming to an acceptance of hearing loss occurs for individuals who acquire a hearing loss in later life. At the same time, the hearing loss that individuals have influences their partners. It then becomes important for couples to obtain an understanding and acceptance of the hearing loss together. They see their relationship through their world view, which in turn influences how they work together to overcome the adversity. Like muscles when exercised, the couple relationship often becomes stronger as a result of coping with communication difficulties. Many couples facing the hearing impairment of one spouse are living resilient lives together. However, there are likely many that are coping less effectively. Audiologists undoubtedly come in contact with couples who run the gamut of resilience. Family therapists may also work with couples or clients with hearing impaired family members. Suggestions for these professionals can give some guidance for informing their work with these clients. Professionals who are informed about the often unspoken and unheard stories relating to hearing loss, can then serve their clients with greater knowledge, empathy, and hope.

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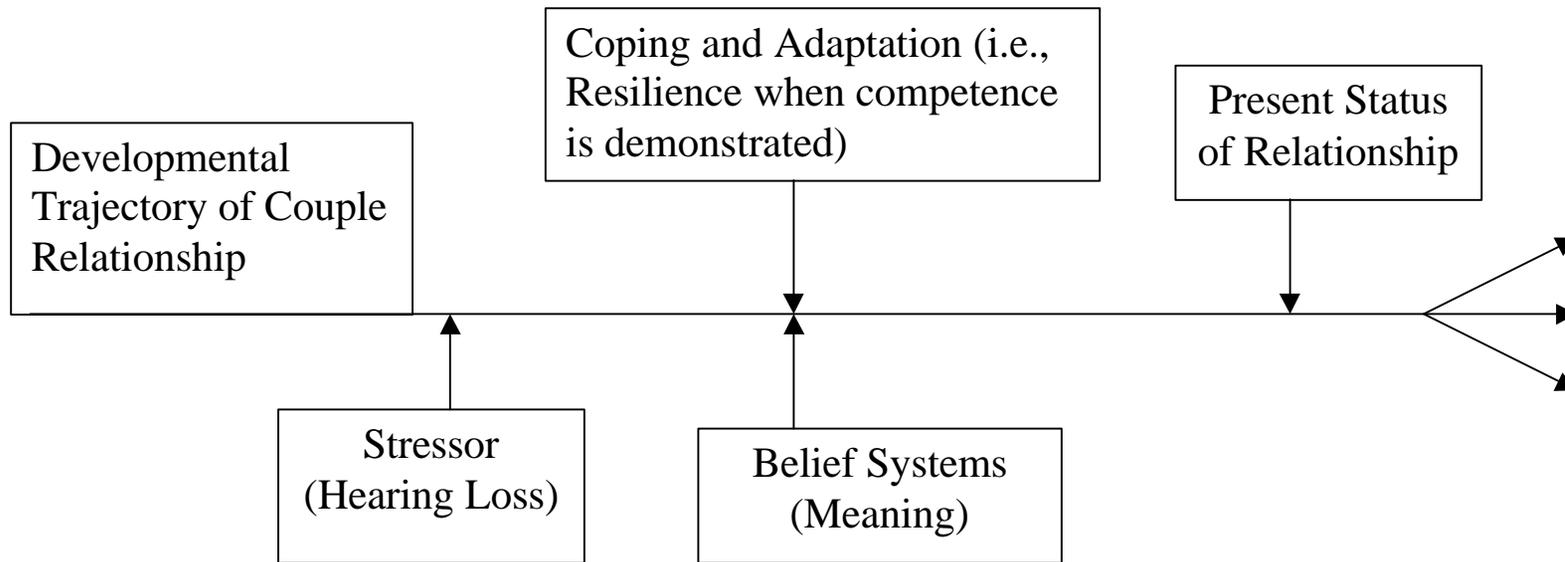
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APPENDIX A

Representation of Couple Resilience Theoretical Framework



APPENDIX B

Couple Recruitment Flier

# Do you or your spouse have a hearing loss?

**If so, you are invited to share your experiences.**

Hearing loss can make it hard for a married couple to communicate sometimes. We'd like to know about your experiences with hearing loss – What's difficult, how you cope, and what it all means to you. We would also like to know what you would recommend to other couples who have hearing losses. If you or your partner has a hearing loss, and at least one of you is 60 or over, we would like to interview you (All interviews are confidential).

**Your experiences are valuable and can be very beneficial to others.**

The researchers will share what they learn with other couples who have similar experiences and with professionals who serve these couples. If you would be willing to share approximately 1½ hours of your time (at your convenience), please contact the Jeremy Yorgason by phone, mail, or E-mail.

**Thank you in advance.**

Jeremy Yorgason, M.S.  
366 Wallace Hall  
Blacksburg, VA 24061

Phone: 540-961-5373  
E-mail: jyorgaso@vt.edu

APPENDIX C

Release of Information for Audiogram and  
Hearing Evaluation Summary

Acquired Hearing Impairment in Older Couple Relationships:  
An Exploration of Couple Resilience Processes

Jeremy B. Yorgason, M.S.  
Fred P. Piercy, Ph.D.  
Virginia Polytechnic Institute and State University  
366 Wallace Hall, Blacksburg, VA 24061

I, \_\_\_\_\_ give permission for the above researchers to have access to my audiogram and a summary of my hearing evaluation (if available).

This information is released for use in a research project related to hearing loss and resilience at Virginia Tech and will not be used for any other purpose.

\_\_\_\_\_  
Research Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

No information sent or received through this authorization may be re-released to any other persons or agency without specific written permission of the above named person.

## APPENDIX D

## Couple Interview Guide

Acquired Hearing Impairment in Older Couple Relationships:  
An Exploration of Couple Resilience Processes

**Interviewer:** I am going to be asking you some questions about your experiences with hearing loss in relation to your marriage relationship. I would like to start by saying that you are experts on living with hearing loss. I have read about it in books, and heard others talk about it, but I have not personally experienced any hearing loss before and so I have come to you to ask about your experiences. One of the reasons I would like to learn more about your experiences related to hearing loss have been is that few studies have ever been done with couples to know what it is like. I would like to share your insight with other couples who may be experiencing similar situations, and with marriage and family therapists who will be working with couples in your situation.

I would like to discuss two areas of your life and marital relationship related to a hearing loss. These areas are (a) the story and meaning of your hearing loss (in other words, I'll ask about the history of your hearing loss, and how you have perceived your experiences), and (b) what has helped you as a couple to overcome difficulties related to the hearing loss. I realize that we will be talking about your personal life, and consequently some private issues regarding your marriage relationship may arise. If at any time you feel uncomfortable answering a question, please feel free to not answer. I hope that our talking today will be an opportunity for you to reflect upon your experiences in a comfortable manner.

### **I. Story**

1. Please share with me in 15 minutes or less the **story** of your/your spouse's hearing loss.

#### **Prompts:**

First notice of symptoms

Was the loss sudden or gradual?

How long has it been since you/your spouse first noticed?

Has your hearing been evaluated? What were you told?

To what degree has your/your spouse's hearing been impaired?

What do you/your spouse believe caused the hearing loss? (ear infections, Meniere's syndrome, aging, noise exposure)

Is the hearing loss experienced in one ear, or both?

2. Do you or your spouse use hearing aids and/or assistive listening devices that are helpful in your daily activities. (Prompt: If you could wear them and you do not, why do you choose not to wear them?) What role does the non-impaired spouse have in the use of hearing aids or other assistive listening devices?

3. What help have you or your spouse received from an audiologist, hearing aid dealer, and/or an ear specialist? (Prompts: When did you first go to a hearing specialist? Did they give you any training or suggestions for your couple relationship?)

4. Has your view of the hearing loss changed since you first noticed it?

5. Have you sought out relationships with others who experience a hearing loss similar to yours/your spouse's?

## **II. Belief Systems and Meaning**

Often the way we act or react in life is shaped by our beliefs or the way we perceive our situation. For example, when good things happen in life we think they happened for a reason. We give meaning to our experiences. Similarly, when difficult things happen in life, we interpret these events according to our beliefs. I will ask you a few questions regarding your beliefs and how you feel you have responded to the difficulty of a hearing loss.

1. What helps you make sense of your hearing loss?
2. Has knowing the cause of the hearing loss been helpful in dealing with your situation? If so, how?
3. Has spirituality or faith influenced your response to your (or your spouse's) hearing loss? If so, how?
4. How does having acquired a hearing loss (for yourself or your spouse) fit with your expectations of growing older?

5. Has it been difficult to understand the hearing loss? Has it seemed manageable?
6. What has your relationship been like since you (or your spouse) experienced a hearing loss? (Prompt: Is there a metaphor that would capture your experience? E.g., story, picture, song, feeling, etc)
7. How has your (or your spouse's) hearing loss influenced your marital Relationship? For the better? For the worse?
8. Some people view life as a time of continuous development. Growth can occur in many different directions. How has the hearing loss influenced the development of your relationship or the growth of your relationship?
9. How do you expect the hearing loss to influence your relationship in the future?
10. What lessons have you learned from your experience with hearing loss? (each other, relationships, family, the world, life?)

## **II. Resilience**

Resilience has been defined as more than surviving or barely getting through a difficulty. It is being able to take charge of your life, live fully, and love well. Life crises can bring out the best in us as we rise to the challenges. I would like to know in what ways, if any, you have overcome hearing loss in your relationship.

1. How has your relationship changed since the hearing loss became a part of life? How has it stayed the same? (Prompt - How have you/your spouse had to re-balance the strains of family and work – in light of your/your spouse's loss?)
2. What situations or environments are most difficult for you to communicate in? What do you as a couple do during these times to communicate? Are there responses that haven't worked best for you? Are there responses that you have found to work great?

3. What has helped you as a couple to withstand or overcome the difficulties associated with losing the ability to hear? (What keeps you going? What do you tell yourself when times get tough?)
4. What role do hearing aids and other assistive listening devices play in your dealing with the hearing loss? How helpful are they?
5. Sometimes couples find what they consider healthy ways of dealing with difficulties, and other times their ways of coping are less healthy. Would you consider any of the coping strategies we have talked about as being healthier than others? (Prompt – Which seem healthiest, and which if any, seem to you to be unhealthy or harmful to your relationship?)
6. What tips would each of you give to others in your situation about how to best communicate between spouses when one of them experiences a hearing loss? If you were going to write a book on how to get along in marriage with a hearing loss, what would you write?
7. What have I forgotten?

Demographic Information

Spouse #1	Spouse #2
Age _____	Age _____
Male ____ Female ____	Male ____ Female ____
Race (Circle one): African American, Caucasian, Hispanic, Asian, Other _____	Race (Circle one): African American, Caucasian, Hispanic, Asian, Other _____
Date of Current Marriage _____	
Occupation (Present) _____ (Former) _____	Occupation (Present) _____ (Former) _____
Highest education attained _____	Highest education attained _____
Audiology Records Yes ____ No ____	Audiology Records Yes ____ No ____
Name of Audiologist _____	Name of Audiologist _____

**V. End of Interview**

Would you like to receive further information regarding coping with hearing loss? If so, are there any specific things you would like to learn about? As a courtesy for letting me talk with you, I would like to give you contact information to some local ear/nose/throat doctors, audiologists, and marriage

counselors that might be of help to you. I do not endorse any of the people or institutions, but would like to give you information that you may find useful.

Thank you!

## APPENDIX E

### Couple Informed Consent

#### Acquired Hearing Impairment in Older Couple Relationships: An Exploration of Couple Resilience Processes

Principle Investigator:

Jeremy B. Yorgason

Virginia Polytechnic Institute and State University

Faculty Advisor:

Dr. Fred P. Piercy

#### **Purpose of this Project**

Hearing loss in mid- to later-life can influence couple relationships in everyday communication, problem solving, affection and intimacy, and ways of supporting one another as companions.

We would like to understand better what couples experience in their marital relationship when one of the partners has a hearing loss. By doing this research, we hope to describe (1) the meaning couples give to hearing impairment, and (2) the relationship strengths seen by couples as leading to resilience and successful development in adulthood.

#### **Procedures**

You and your spouse will participate in an interview for approximately 60 minutes together. The interviews will take place in your home or in an alternate place decided upon by yourselves and Mr. Yorgason. You will be asked between 10 and 15 questions in the interview (a copy of the questions are attached for your reference). Once the interviews have been transcribed, the themes that are identified will be taken to a professional focus group of marriage and family therapists. A copy of your audiogram will be requested. Lastly, the researcher will send you a copy of preliminary results so that you can clarify them and add any suggestions.

#### **Benefits**

No monetary compensation will be given for participation in this project. However, you may find benefit in examining your life and the impact that a hearing loss has on your marriage relationship. You may also request a copy of the results of this project from the investigators. The information that you share will also be of great benefit to others who are in similar situations as yourselves.

### **Risks**

You will be asked about your personal thoughts regarding your/your spouse's hearing loss, and what meaning it has for you in your marriage. Exploring how the hearing loss has influenced your relationship may possibly cause some emotional distress by encouraging you to reflect on painful experiences. However, you are not required to answer any questions that make you uncomfortable with and you may request to stop the interview at any point.

### **Confidentiality**

Your responses will be held in strict confidence. When a report is written, a pseudonym will be connected to your responses, and the researcher will report your responses in a way that readers will not be able to identify you.

I would like to audio tape the interviews so that I can listen closely to the ideas that you share with me. The tapes will be kept in a locked filing cabinet and will be destroyed once they are transcribed. Only the researchers will have access to the tapes. You may request that the recording of your interview be given to you once it is transcribed.

You are free to withdraw from the project at any time without penalty. You also do not have to answer any questions that you do not wish to answer.

This research project has been approved, as required, by the Institutional Review Board for Research involving Human Subjects at Virginia Polytechnic Institute and State University and by the Department of Human Development.

July 24, 2002  
IRB Approval Date

July 24, 2003  
Approval Expiration Date

**Your Responsibilities:**

I voluntarily agree to participate in the interviews described above. I have read and understood the Informed Consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Should I have any questions about this project or its conduct, I may contact:  
Jeremy B. Yorgason      Phone: 231-7201      E-mail: jyorgaso@vt.edu

Fred Piercy, Ph.D. Phone: 231-6001      E-mail: piercy@vt.edu

Or

David M. Moore      Phone: 231-4991      Email: moored@vt.edu  
Chair, IRB  
Office of Research Compliance  
Research & Graduate Studies

## APPENDIX F

## Kansas Marital Satisfaction Scale

Item	Extremely Dissatisfied	Very Dissatisfied	Somewhat Dissatisfied	Mixed	Somewhat Satisfied	Very Satisfied	Extremely Satisfied
How satisfied are you with your marriage?	1	2	3	4	5	6	7
How satisfied are you with your relationship with your wife/husband?	1	2	3	4	5	6	7
How satisfied are you with your husband/wife as a spouse?	1	2	3	4	5	6	7

APPENDIX G

Recruitment E-mail Message for Focus Group Participants

Dear <<Clinician>>,

My name is Jeremy Yorgason. I am a marriage and family therapy student at Virginia Tech. I'm conducting a study that involves the participation of selected marriage and family therapists who are in or around the New River Valley. I found your name and credentials in \_\_\_\_\_ (e.g., the NRV directory of mental health providers, or by referral).

For my dissertation I'm studying the experiences of older couples where one spouse has a hearing loss. I have conducted a number of interviews with older couples and I have learned a lot about how they deal with the couple relationship adjustments that accompany a hearing loss. I'm now interested in looking at the clinical implications of what they told me and so I'm asking a small group of experienced family therapists to meet, consider the themes from my interviews with these couples, and talk about how these themes might translate into clinical work with couples in which one partner has a hearing loss. (Basically I'm doing a one-time focus group with local MFTs regarding working with couples in therapy where one spouse has a hearing loss.)

The meeting I would like to invite you to come to is tentatively scheduled (with a light dinner served) for March 14th, from 5:30 to 7:30. I have also set aside some alternative times. Please let me know if any of these other times would work with your schedule:

Friday the 7<sup>th</sup> starting at 5:30pm  
Tuesday the 11<sup>th</sup> starting at 5:30pm  
Friday the 14<sup>th</sup> starting at 9:00 or 10:00am  
Saturday the 15<sup>th</sup> starting at 10:00am

The meeting will be held on the 14<sup>th</sup> at 5:30pm or at the alternative time that works best for those invited.

Would you be willing to meet with me and other local MFTs? Let me know if you would be able to attend.

Thanks,  
Jeremy Yorgason

APPENDIX H

Follow-up Recruitment E-mail Message for Focus Group Participants

Dear <<Clinician>>,

Thank you for accepting my invitation to attend the focus group at the Virginia Tech Family Therapy Center on Friday March 14th. The Family Therapy Center is located in Blacksburg, behind the Rite Aid Pharmacy on University City Blvd. The street address is 840 University City Blvd., and the Family Therapy Center is located in Suite #1 (the first door on your right as you enter the building).

A light refreshment will be served at 10:00 a.m. The meeting will follow the refreshments and conclude (we promise) by 12:00 noon.

The discussion you will be attending will be a forum of experienced Marriage and Family Therapists who work (or worked) in the New River Valley or surrounding area. We will be discussing the clinical implications of what older couples have told me about hearing loss and their relationships. Basically, I would like to share these findings and ask you to reflect on how they would inform your clinical work with such couples. At the conclusion of the session I will give you a small gift as a token of my appreciation.

If you find for some reason you are not able to attend, please contact me (Jeremy) at 961-5373, as soon as possible.

I look forward to seeing you on March 14th.

Sincerely,

Jeremy Yorgason, MS  
Doctoral Candidate in MFT  
366 Wallace Hall  
Blacksburg, VA 24061  
H: (540) 961-5373  
W: (540) 961-8356  
E-mail: jyorgaso@vt.edu

Fred P. Piercy, Ph.D.  
Chair, Department of Human Development

## APPENDIX I

### Focus Group Informed Consent

Project Title: Acquired hearing impairment in older couple relationships: An exploration of couple resilience processes.

Investigators: Jeremy B. Yorgason, M.S. & Fred P. Piercy, Ph.D.

#### Purpose

The purpose of the focus group meeting is to explore the perceptions, attitudes, and opinions of marriage and family therapists as they reflect on and discuss the reports of couples where one spouse experiences a hearing loss.

#### Procedures

You will take part in a 1½ hour focus group of marriage and family therapists. The focus group discussion will be audio taped and then transcribed. Your name will not be associated with either the transcript of the discussion, or any document summarizing the information obtained from this discussion.

#### Risks

We don't anticipate any risks to you beyond those you would experience in any discussion of marriage and family therapy issues with your peers. However, it is possible that certain focus group questions may raise issues and/or experiences that you may find potentially uncomfortable. Remember, you do not have to answer any question you do not want to answer, and you may stop your participation in the focus group at any time.

#### Benefits

This focus group evaluation will provide clinically relevant information related to reports of couples where one spouse experiences a hearing loss. You will have the opportunity to share your perspectives, and perhaps even shape future studies by calling attention to issues that you believe are important to couple relationships where a hearing loss has occurred. The focus group data will help both the researchers and other marriage and family therapists to better understand the experiences of couples where one spouse has acquired a hearing loss.

#### Confidentiality

The audiotape of the focus group sessions will be erased once a transcription has been made. Your comments will be treated with confidentiality. Your name will not appear on the transcript, and it will not be associated with any report or discussion related to the focus group data.

You are free to withdraw from this evaluation at any time without penalty. You may also choose not to respond to any question without being penalized.

This project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University, and by the Department of Human Development.

July 24, 2002  
IRB Approval Date

July 24, 2003  
Approval Expiration Date

**Your Responsibilities**

I voluntarily agree to participate in this study. I understand that my responsibilities include participating in a 1½ hour focus group.

I have read and understand the Informed Consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent.

\_\_\_\_\_  
Subject Signature

\_\_\_\_\_  
Date

Should I have any questions about this project or its conduct, I may contact:

Jeremy B. Yorgason                      Phone: 231-7201                      E-mail: jyorgaso@vt.edu

Fred Piercy, Ph.D.                      Phone: 231- 4794                      E-mail: piercy@vt.edu

Or

David M. Moore                      Phone: 231-4991                      Email: moored@vt.edu  
Chair, IRB  
Office of Research Compliance  
Research & Graduate Studies

## APPENDIX J

### Focus Group Guide

#### **Welcome group participants:**

Hand out Informed Consent Forms

**Purpose:** To focus as a group on the findings from couple interviews with later life couples where one spouse has a hearing loss. Therapists will share their clinical expertise in interpreting and exploring the themes that were categorized from couple interviews. At the same time, group participants will be informed on couple issues relevant to an acquired hearing loss.

#### **What will be done with the focus group information?**

I am tape recording the focus group and will transcribe the discussions to look for themes and quotes that represent or highlight these themes. Pseudonyms will be created as I transcribe the discussion so that no names and identifying information will be given in the results.

#### **How the focus group will work:**

A focus group is basically a group discussion. We will meet for about an hour and forty-five minutes. I'll ask a series of questions. For each, you will have the opportunity to respond, to react to, elaborate on, agree with, or disagree with other's responses. There's no one right answer, so we won't be trying to come to any consensus. Basically, we'd like to hear all opinions.

#### **Ground Rules**

- ◆ Respect
- ◆ One person talks at a time
- ◆ Confidentiality (no names will be associated with anything you say)
- ◆ Its OK to choose not to answer a questions
- ◆ Its OK to disagree
- ◆ No right or wrong answers

**Introductions:** Share some information about myself and then invite group participants to introduce themselves.

**Present major themes and examples of themes from couple interviews.**

**Vignette – *The Gardners*.** I contacted the Gardners by phone prior to interviewing them. They kindly agreed to participate in the study. The hard of hearing husband, Jerry, answered the phone and asked to have his wife (Amanda) get on the line to coordinate schedules. I hadn't realized that Jerry had stayed on the phone until almost the end of the conversation when he made a comment. I wondered if Amanda did a lot of the talking [on the phone] in their relationship.

I arrived at the Gardner's home at about 9:30AM on a clear day that was cool and sunny. The house appeared to have been built in the early 1980s, and the yard was mixed with overgrown shrubs and a couple of rusty iron pieces of abstract art. Two cars were parked in the drive-way; one was an old car that looked to be a model that came out in the 1970's, and the other one appeared to be a model built in at least the 1990's. Inside of the house, the walls were covered with beautiful artwork. The contrast between the old and the new in the surroundings appeared to parallel some aspects of the couple relationship. In some ways their relationship appeared to be based on traditional values, yet in other ways they were very open to exploring what was unknown to them.

I was greeted warmly by Jerry, who escorted me into the living room. Amanda then came upstairs into the same room, letting in two large, friendly dogs from the back porch area. Jerry, a 75 year-old college professor, had taught at the university for many years, and was still teaching. He shared several experiences throughout his life that may have led to a hearing loss.

Amanda was born in 1929. She and Jerry married in 1954, and they had raised 2 children together. Amanda was educated an elementary school teacher, and had worked as a stay-at-home mother and housewife after the first child was born. She first noticed Jerry's hearing loss when he would not respond to something she had said. He would just look at her as if he didn't understand what she was saying to him. Jerry reported that he had many ear infections as a child, and that after going hunting his ears would ring for a few days. In addition to the hearing loss, both Amanda and Jerry reported to have experienced multiple health conditions throughout their lives. They attributed their couple resilience to all of these experiences, including the hearing loss.

To my surprise, and different from what my experience was with this couple on the phone, Jerry spoke first most of the time and it seemed that he spoke more than anyone else during the interview. He seemed pleased that someone would be interested to hear his story. Jerry reported to be able to understand his loss because his father has acquired a hearing loss in later life. He had struggled with some depression when he first lost his hearing, but had come to accept his loss over the years. Jerry and Amanda don't go out as much as they used to, but they still enjoy company in small group settings. Amanda sometimes repeats things in public when Jerry hasn't heard a question or comment. She is continually on the look out for him in group situations. They reported that the most difficult part of the hearing loss was the sudden loss in Jerry's left ear (on top of his gradual loss in the right ear).

What questions would you have for this couple if they walked into your clinic?

**1. Relationship stressors – Present one problem for each focus group participant and then ask the group to respond to each situation.**

**A. Driving**

H: Yeah, driving. She is on the wrong side and if I turn to read her lips, I scare her to death or she is afraid I will run off the road or run into something.

W: But then on the other hand I drive, he can hear me just fine. But the only time we can talk is out on the interstate because I can't drive and talk in town at all. I just lose...

H: She has to concentrate on her driving.

**B. Talking on the Phone**

H: It is for me on the telephone if I am talking to her, I have a tendency to switch subjects. I think most of us do. Talk about two or three different things on the phone. But I forget and I start to tell her one thing and then I start to tell her something else, and she gets frustrated with me because she can't understand me and we end up saying that we will just talk about it later because I can't get across what I am trying to explain to her. . . .

J: Yes, yes. When you realize that you have forgotten,

H: I have to come home and apologize, and tell her I am sorry and that I switched horses in the middle of the stream and I know better than to do that, but I forget. Because my hearing is good. It doesn't bother me if you talk about 100 things at one time. I know it does her and I shouldn't do that. But I forget and then I get mad at myself because, "buddy you've done it again."

W: He feels bad because he knows it will upset me.

H: I know I have gotten her frustrated because I've changed the subject, and I knew better, I knew that I shouldn't do that. But for some unknown reason, you just do it naturally. I don't know if that's what you're ...?

J: Yes. Do I dare go one step further? What I am wondering is so when you come [home]... What does that look like?

W: Well he says he will talk to me later about it.

H: Usually on the phone we end up, I say I'll just have to explain it to you later, rather than to continue as she's getting more frustrated. And

I'll say, "Let's just talk about this later." And then we talk about it later and I'll tell her what was actually going on, and of course she understands why what I did and we just talk it out and go on and not get bent out of shape. It's just one of those things that are my faults, that I'm still working on, but I forget.

J: And that is what you have learned to do. You've learned to say "OK, lets wait, let's talk later."

H: Right, "I'll tell you about it later because you can't get it." There's no sense in keeping on talking... because she's getting more frustrated. And I don't want her getting more frustrated. She doesn't want to get more frustrated. Then we both get frustrated. Might as well drop it and talk about it later in person.

### C. Mumbling

H: I have a couple of things. If she doesn't quite hear something sometimes she will, I can't always hear whether she has heard. And I would much prefer being told, "Could you say that again. I couldn't hear what you said." And my response must then to be, to say it more clearly, and not to yell it.

W: And I am at fault sometimes at not answering right away. Because I don't know what I have heard and I am hoping he will say it again without me asking him to say it again. Or I really, I am trying to really run my recorder and "What did I hear?" And so I am hesitating and there's a pause and it is long enough that he is wondering if I have heard anything at all.

H: Lots of times...

W: That happens quite a lot.

H: Lot's of times it is useful if you tell somebody something and they say, "Ok." Rather than no response.

### D. Embarrassment

H: This leads to the climax for me was very embarrassing another couple was carrying on a conversation and she was not able to answer it. And when they asked what time it was, she would be talking about the birds.

W: Ha.

H: It was very obvious she didn't know.

W: To them too of course.

H: So that was embarrassing I had the feeling like I had to cover up for her or answer the question she didn't understand. I guess that was the most difficult thing for me. I felt she wasn't really herself. If other people were seeing this.

**E. Shouting**

H: When I had a question and she was downstairs. She couldn't hear you. Holler and holler and holler and finally I'd go down. I don't know whether she doesn't want to answer or whether she can't hear.

W: The whole downstairs is finished, we have an apartment down there. And he was all the way out in the garden and he came to tell me something. Well I am right in the middle of doing something and I can't stop what I am doing.

**2. Individual stressors – Each of the couples described stressors, related to hearing loss, that affected one spouse. Some of these included**

- a. Difficulties with hearing aids
- b. Being isolated and lonely
- c. Anger and depression
- d. Embarrassment in social situations
- e. Repercussions of hearing related disease (Cysts, Meniere's disease – dizzy, noises)
- f. Other Health Problems (heart, cancer, neural problems, etc.)
- g. Can't hear phone
- h. Communication becomes emotionally draining
- i. Difficulty interacting with children/grandchildren
- j. Not severely challenged/not that difficult/time so special – hard to imagine it being tough

How would you interpret these findings from a relational or systemic view?

**3. Understanding and Acceptance (through acknowledgement of loss and knowing the cause of the loss) –**

- a. Etiology –
  - i. Genetic, disease, loud noises – military or hunting
  - ii. Normal Aging processes
  - iii. No Meaning
- b. Acceptance – no longer ashamed, able to move on
  - i. “You accept aging, kicking and screaming, of course”
  - ii.

H: It hasn't held her back. She goes on and does whatever it takes to get through life. I am sure she gets frustrated

sometimes. Especially with the telephone because we all like to chit-chat on the phone. And she can't do that.

W: Well, it is a loss for me. But I had to learn to accept it.

From your theoretical/clinical perspective, what importance would these themes have if this family were being seen by you in therapy?

**4. Expressions of values and beliefs – (gratitude, optimism, humor, and pleasure)**

- a. Gratitude –
  - i. I'm thankful that I am not really deaf. I am thankful and glad that I am able to hear with a hearing aid.
  - ii. "You talk about meaning of hearing loss. It [hearing loss] is small compared to what other people have suffered all around me."
- b. Optimism
  - i. "I have enjoyed each step of the way and I am enjoying it now. And I look at the good side."
- c. Humor
  - i. We laughed a lot in the interviews themselves
  - ii. Couples joked about the hearing loss –

"We laugh sometimes, he has better eyes than I do. With his glasses. I have a problem seeing road signs and so he reads road signs for me if I am driving. And well, great. When I get so I can no longer walk because I can't see, I'll get a wheel chair and he can push and I can, he can see when the light turns or whatever and I can hear the policeman buzzing at us. Ha. And off we will go."
- d. Pleasure
  - i. Able to hear birds again, running water
  - ii. Smiling at the audiologist when hearing aid first put in
  - iii. Play the piano again after stopping for 15 years
  - iv. Loss of pleasure – no longer able to listen to music

In light of what you know about hearing loss and the relationship dynamics associated with it, how would you use these in therapy?

**5. Care-giving –**

- a. Signs for when hearing aid is squealing (due to feedback)
- b. Dependence – "I would be lost without him."
- c. Side by side –
  - i. W: "When we go somewhere, he always stays right beside me because of my hearing --so we can talk.  
H: That is just something I have learned to do."
- d. Spouse as interpreter, alarm clock, scout, "mothering"

What patterns of interaction might you look for when care-giving is involved in couple relationships? Are there any red flags that you might look for?

**6. Humor and Re-balancing –**

- a. Couple #2 Example (see printout)

How similar is this pattern to what you have experienced with couples in therapy? What information do you glean from this type of interaction?

**If extra time:**

**7. Development of Couple Relationships –**

- a. Couple #1 – Commitment, devotion, patience, love
- i. “H: Our devotion to each other is much stronger than it was when we first started out 40 years ago. And it gets stronger. And I think difficulties, even her hearing problem, or other difficulties makes your devotion, if you really love each other, and really you know, it really makes your love deeper and stronger. Draws you closer together. Of course that goes along with your spiritual beliefs too. I'm not a fanatic. But we are Christian and we do love each other, and we trust in our spiritual relationship with God.”
- b. Couple #2 – Incremental changes in social interaction – don't mind a change in emphasis, but would like to become more involved socially - to some degree. (**Rocky Mountains vs. Appalachians**)
- c. Couple #3 – More confidence in couple communication since purchase of hearing aids. Fewer embarrassing social situations.
- d. Couple #4 – Struggle of hearing loss has influenced relationship for the better (Age related change – expected loss).
- e. Couple #5 – Balance between independence and dependence (mothering at first) – He makes calls to refill prescriptions. Some change in social activities.

How do you perceive that health factors influence the development of couple relationships? How much attention do you think MFTs need to give to health issues that their clients face?

**8. Gender –**

- a. Hearing Aid cost – women in this study expressed concern/worry over the cost of hearing aids and how their husband might respond to their desire to make this purchase. Men might also worry. The breadwinner spouse might voice less concern, and men might be less verbal about their concern.
- b. Vanity and hearing aids – Women expressed that they chose hearing aids based on size, look, etc. Men may be equally concerned, but did

not voice this in the current study. Men may appear inadequate or feel less macho with having to wear hearing aids.

- c. Male vs. Female expression of feelings
  - i. W: I think the thing that for a hearing impaired person is to learn to communicate their feelings. I think women are better about that than men are. Men are notorious about not sharing their feelings. I think that is one thing. He is frustrated. Or at one point he was going to bed at 8:30 because of the trauma of the television noise and he takes his shower go to bed and read.  
H: Communicate[ing] is really hard.

Gender might influence the use of assistive listening devices, acceptance of hearing loss, or other behaviors related to hearing loss.  
How would you address this in therapy?

**Prompts or additional questions:**

What findings do you find surprising?

Describe any interventions that come to mind.

What findings do you consider to be most important?

How would you as a clinician use the information I have just shared in your clinical work?

Do you have any unanswered questions in regards to the experiences of these couples?  
In other words, if they were here, what else would you ask them?

## APPENDIX K

## COUPLE PROFILES

*Couple #1*

**The Akers.** John and Alice Akers were referred to me through their hearing aid dealer from Roanoke. They were the only couple that responded to the recruitment fliers that went out to audiologists and hearing aid dealers. John called me at work after he got the flier and then he called and emailed several times before the interview, and seemed very eager to help with the study.

I drove to a small town in the New River Valley on a Saturday afternoon to interview the Akers. I came to a somewhat small home with a recently paved driveway. One of the vehicles parked in the drive was fairly new and the other was older. I noticed several houseplants on the porch. There was a fairly large back yard with trees and grass. The home looked like it had been there for some time, and some of the furniture was also seemingly from previous decades. I was ushered into the kitchen and then the couple discussed whether we needed to meet in the kitchen or if we should meet in the family room. They decided on the family room, although I got the sense that the wife (with the hearing loss) would have preferred to meet in the kitchen at their small table where we would all be facing each other. In the front room I was instructed to sit on the end of the couch, the wife sat in the middle, and the husband on the other end of the same couch. I was on the side of the hearing aid and so the wife had to turn her head to listen to her husband whenever he spoke. I noticed several plants in the family room also, along with many pictures of family. It seemed as if the couple had lived in the same house for a long time – there were many little things here and there, including lots of little collectibles.

Alice had experienced a hearing loss as a child, as a result of several ear infections and red measles disease. She started wearing a hearing aid at the age of 4. She took speech classes and had learned to lip read. John and Alice had been married about 40 years. John worked in finances and Alice had worked as a library aid and then in merchandising. After about 30 years of marriage, Alice began losing more hearing, which required additional adjustment in the relationship. Alice wore one hearing aid in her good ear and she used closed captioning with the TV. She struggled the most with talking on the phone. She had to give up talking to family members on the phone because she became frustrated when she did not understand what was said. She still spoke with John on the phone frequently, but whenever he changed the subject it became difficult for her to follow and she would become frustrated.

Despite the struggles of Alice's hearing loss, the Akers portrayed a sense of closeness, dependence on each other, commitment, love, sharing, patience, tolerance, and having a positive attitude. They reported having other, more serious health problems that they thought were of greater significance in their lives than the hearing loss. One of these included severe heart problems reported by the husband. Overall, the Akers exhibited resilience in their response to the wife's hearing loss.

*Couple #2*

**The Stevensons.** Melanie and Shawn Stevenson were the first couple of the snowball method, being referred from an acquaintance of mine. They were happy to be of help in my study, and gave me names and contact information for two other couples.

One Saturday morning in the Fall I drove through a windy steep road and turned into a steep, long driveway. The house was surrounded by natural growing trees and ground cover, a long row of beautiful log stumps lined the driveway.

Shawn kindly greeted me at the door and led me into the home to the main level where paintings and art work lined the walls and were lined up along the floor. The art work included abstract works and also some portraits. Once upstairs I was introduced to Melanie, who is the artist. We sat at the kitchen table – I on the left of the wife, and the husband on the right of the wife (hearing loss in left ear). As I looked around my senses were almost overwhelmed because there were so many things the eyes could focus on.

Shawn was a retired professor that continued to conduct some research. Melanie had suffered a hearing loss in her left ear. She had been diagnosed with Meniere's disease, which can cause hearing loss. She also attributed her hearing loss to genetics – having seen several family members struggle with problems similar to hers.

The Stevensons had been very socially active throughout their nearly 45 years of marriage, but this had changed with Melanie's hearing loss. They had to limit their attendance to group gatherings and civic events – something Melanie would like to see change as she and her husband become better aware of her needs.

Shawn and Melanie were not sitting particularly close to each other, yet they spoke often of their love for one another. They also liked to joke – especially the husband. Sometimes the wife didn't think it was funny. In fact, often times Shawn's jokes were sarcastic and pointed at Melanie's hearing loss or her personally. Melanie chided back at times, yet ultimately in the interview the couple seemed to balance the conversation out by giving positive comments about the other.

*Couple #3*

**The Johnsons.** Stacey and Wally were another referral from a friend, and were happy to be of help in the study.

I awkwardly drove through the backstreets of Blacksburg, trying to read the directions I had been given while driving. This was a part of town I was not familiar with. I wound through some streets lined with fields and then came to a small group of condominiums. The Johnsons condo was small yet neat. The yard was nicely groomed and a small driveway and sidewalk led to the front door. I was greeted by both Stacey and Wally at the door. I was welcomed in and invited to sit in a comfortable chair across from the two of them. I set up my recorder and microphone on the coffee table and began a very cordial conversation.

Wally, a retired engineer, and Stacey, a retired school teacher and banker, had been married around 10 years. It was a second marriage for both, each having lost their previous spouse. Stacey shared that she had noticed some signs of a hearing loss a few years after their marriage, but that she had denied any problems for a long time. Wally began to notice that Stacey did not quite hear all of the words during social gatherings. This embarrassed Wally, and was especially difficult when Stacey would respond to a question or comment that was very different from what was actually said. Stacey had a family history of hearing loss, with her father and sisters having hearing problems. At the prompting of a friend, Stacey decided to look into hearing aids. She purchased the most discrete model – completely in the canal hearing aids. She preferred them because they could not readily be seen. In fact, I believed she must have taken her hearing aids out to be able to talk with me. At any rate, Stacey loved the hearing aids and she has been a lot more comfortable in social situations. Aside from the social struggles, the Johnsons reported to be almost like newly weds. They expressed that they were very happy as a couple.

***Couple #4***

**The Jones.** Tom and Louise were a referral from one of the other couples in the study. They did not seem overly excited to participate, yet they were willing to help with the study.

I quickly drove to a familiar part of town and made my way down a little lane to the Jones' home. I had been here a week previous to today when I got mixed up on what house to go to. They lived in a nice home at the end of a dead end street. The lawn was nicely mowed and they had a couple of large maple trees in the front. I also noticed their basketball standard in the driveway. Tom was home alone at first and then Louise came in after we had chatted for a few minutes. I was invited to a small room next to the kitchen. It was almost an indoor patio to the back yard – with windows facing the trees, and posters, books, etc. filling most of the wall space. I noticed that Tom had a hard time hearing me a few times and then I asked which one had the loss and it was Louise. Oops!

Louise had experienced a very gradual hearing loss that she attributed to normal aging processes. At the encouragement of a friend, she had purchased hearing aids approximately 3 months previous, and had found them to be very helpful. Tom acknowledged that he had a slight hearing loss also, but that Louise was the one with the hearing aids. Tom and Louise struggled the most when they wanted to communicate from different rooms. Sometimes Tom would call to Louise and when she was busy she would want to finish her task before responding. This was sometimes upsetting to Tom, who did not know when Louise could not hear him or if she might just be ignoring him.

Tom and Louise had been married for 51 years. He was a retired professor, and she was previously an elementary school teacher. They said they had lived in Blacksburg for over 60 years! They raised 3 children and seemed to have a very nice relationship. The Jones expressed that they did not feel like they had been affected much at all by the hearing loss, and as a result their answers to my questions were typically short or not at all.

*Couple #5*

**The Gardners.** I contacted the Gardners by phone prior to interviewing them. They kindly agreed to participate in the study. The hard of hearing husband, Jerry, answered the phone and asked to have his wife (Amanda) get on the line to coordinate schedules. I hadn't realized that Jerry had stayed on the phone until almost the end of the conversation when he made a comment. I wondered if Amanda did a lot of the talking [on the phone] in their relationship.

I arrived at the Gardner's home at about 9:30AM on a clear day that was cool and sunny. The house appeared to have been built in the early 1980s, and the yard was mixed with overgrown shrubs and a couple of rusty iron pieces of abstract art. Two cars were parked in the drive-way; one was an old car that looked to be a model that came out in the 1970's, and the other one appeared to be a model built in at least the 1990's. Inside of the house, the walls were covered with beautiful artwork. The contrast between the old and the new in the surroundings appeared to parallel some aspects of the couple relationship. In some ways their relationship appeared to be based on traditional values, yet in other ways they were very open to exploring what was unknown to them.

I was greeted warmly by Jerry, who escorted me into the living room. Amanda then came upstairs into the same room, letting in two large, friendly dogs from the back porch area. Jerry, a 75 year-old college professor, had taught at the university for many years, and was still teaching. He shared several experiences throughout his life that may have lead to a hearing loss.

Amanda was born in 1929. She and Jerry married in 1954, and they had raised 2 children together. Amanda was educated an elementary school teacher, and had worked as a stay-at-home mother and housewife after the first child was born. She first noticed Jerry's hearing loss when he would not respond to something she had said. He would just look at her as if he didn't understand what she was saying to him. Jerry reported that he had many ear infections as a child, and that after going hunting his ears would ring for a few days. In addition to the hearing loss, both Amanda and Jerry reported to have experienced multiple health conditions throughout their lives. They attributed their couple resilience to all of these experiences, including the hearing loss.

To my surprise, and different from what my experience was with this couple on the phone, Jerry spoke first most of the time and it seemed that he spoke more than anyone else during the interview. He seemed pleased that someone would be interested to hear his story. Jerry reported to be able to understand his loss because his father has acquired a hearing loss in later life. He had struggled with some depression when he first lost his hearing, but had come to accept his loss over the years. Jerry and Amanda don't go out as much as they used to, but they still enjoy company in small group settings. Barbara sometimes repeats things in public when Jerry hasn't heard a question or comment. She is continually on the look out for him in group situations. They reported that the most difficult part of the hearing loss was the sudden loss in Jerry's left ear (on top of his gradual loss in the right ear).

*Couple #6*

**The Daines.** Hugh and Kathy were referred from another couple that had been interviewed. My communication with the Daines was mainly through email with Hugh, as that was the contact information I had been given. The couple seemed somewhat reluctant to participate, but also willing to help.

I drove one afternoon up through the hills of Virginia to reach the Daines' home. It was a beautiful drive through a community of large homes built throughout what seemed to be a forest of trees. The Daines lived in a home with a drive that sloped down around to the back of the house. I was grateful that no snow was on the roads that day!

Hugh and Kathy had been married for nearly 40 years. Hugh was still working as a professor, and Kathy described her occupation as a "domestic engineer." Hugh's father had used hearing aids since the age of 40, and one of his brothers had a significant hearing loss at about the same age. Hugh started noticing problems also around age 40. He specifically recounted that he noticed problems when he was at a professional conference and he could not understand the questions being asked of him. He also said that following hunting trips his ears would ring for days. Hugh loved music, and gave up much of what he loved (including playing the piano) until recently when he acquired new digital hearing aids. With these aids, he said that the sounds he heard resembled much better the sounds he used to hear.

Hugh and Kathy struggled the most when they were not facing each other while talking. This can be frustrating to both as Hugh cannot hear what was said, and Kathy has to repeat herself. Hugh also reported to dislike that he struggled to communicate with grandchildren. One strength that the Daines shared is that they have a set routine in the mornings. Hugh doesn't put his hearing aids in until after breakfast, but they have become accustomed to a way of doing things that is satisfactory to both. Hugh and Kathy seemed to still be struggling to adjust to the hearing loss, although technological advances have helped recently.

***Couple #7***

**The Poreskys.** I communicated with Bob and Jackie Poresky by phone and email in preparation to interview them for the study. When I first contacted Jackie, she mentioned that she was going in for hip replacement, and so I didn't contact them again for a couple of months. She said at that time that her marriage was under considerable strain. She couldn't go up/down stairs, ate all of her meals in bed (cooked by her husband), and that she would have surgery soon. She also said that she wouldn't be alive without her husband. The first meeting with the Poreskys was cancelled because the wife had the flu.

I drove a very short distance to reach the Poresky's home. The house was nestled in a grove of Virginia hardwoods, and overlooked a beautiful valley. As I drove down their driveway, I noticed that their house is very artistic in nature. There is a large red triangle on one end of the house, and there is also a large painting on the wall next to the front door (hiding the door bell☺). I soon learned that Bob worked in architecture and that Jackie was an artist.

I was greeted at the door by Bob. He led me into the house and said that his wife would be right down. The level of the house I was on was an open level with a kitchen, dining room, front room, a back office, and a corner with a nice bed. The bed was on that level to allow Jackie access to the bathroom without climbing stairs. Also in the house were several abstract paintings and two very tall (about 15 feet) rusty metal pieces of artwork. The table was covered with several hundred slides, and it was apparent that the couple worked and lived in these rooms.

I sat on the sofa, and the couple each sat in chairs that were side by side facing me. Their chairs were metal framed, with leather seats. A large Siamese cat strolled around for the first few minutes.

Jackie had several sore throats when young, and noticed a slight hearing loss while in the third grade. Bob had not noticed any hearing problems in Jackie when they were first married 40 years ago. When in her late 20s to early 30s, Jackie's hearing ability decreased significantly. Jackie's father had a hearing loss, which helped her to feel that her loss was somewhat expected. She led a support group for the hard-of-hearing at a local nursing home for some time. She also became very educated about her hearing loss.

The Poreskys were frank and honest about their situation, and openly stated that they had difficulties communicating at times. This was apparent as throughout the interview I was asked to repeat myself several times, as was Bob. At the same time, the couple expressed warmth and love, and at one point in the interview Jackie leaned over and touched Bob's arm and then they held hands for a few minutes.

The Poreskys were able to express their experiences, thoughts, and ideas very precisely and in a way that I have not seen to this point. They seemed to be deep thinkers and feelers, and they were able to express this at both positive and negative ends of this spectrum.

**Couple #8**

**The Greens.** Jack and Heather were referred from a co-worker, who knew them from church. They were very interested in being interviewed, and very open to share their experiences and ideas.

I pulled up to their home and first off noticed the trees and shrubs in their front yard. Some of the trees were very mature – maybe 30-40 years old. Hanging from a couple of the trees were several home-made bird feeders of different sizes and shapes. Up again on the porch were another group of bird feeders made of plastic bottles. I was greeted warmly by a kind elderly woman (Heather). She welcomed me into their home and then went to look for her husband. I sat on the couch and then the husband came over and sat on a Lazy-boy recliner in the center of the room. It wasn't but a few minutes before he asked to have a different arrangement of the seats. He came and sat next to me on the couch, with his best ear (right) next to me, and his wife sat on a rocking chair just to his left.

Jack and Heather had been married for 22 years, in the second marriage for both of them. Prior to retirement, Jack had worked in telecommunications and had been a radio announcer. Heather was a retired professor in clothing and textiles. My co-worker first warned me, and then I was warned again by both Jack and Heather that Jack enjoyed talking, and that I would have to be assertive I wanted to ask a question. This held true throughout the interview.

Jack attributed his hearing loss to several factors. He had gotten sick when he was 5 years old, and had boils in his ears. His father had a hearing loss, and Jack was in the military. Jack would sit in the front of the class during school and took speech lessons as a teen, but did not get a hearing aid until he was in his mid 40s.

It seemed that the greatest struggle for Jack and Heather was that when Heather wanted to talk, Jack did not listen as well as she would like. He would have difficulty hearing the first part of her phrases, and then she reported that he would be busy thinking of what he was going to say next. Jack insisted that people speaking to someone that is hard-of-hearing needed to begin each conversation with some gesture that got their attention. Heather wondered if he may have had the tendency to talk so much in order to not have to listen as much. The communication difficulties over the years seemed to have created some distance between Jack and Heather.

While telling the story of his hearing loss, Jack became choked up a number of times and asked that the tape recorder be turned off at those times. He was reminiscing his first days in the radio business, his days of elocution training (speech training), and those things that set him on his life's path. The wife stated that she had heard these stories over 100 times, but had never seen him get choked up like this.

From a structural standpoint, the husband was next to me, and the wife was somewhat distanced from him, but facing me. They were not "together" so-to-say. At the end of the interview, the husband gave me a pile of pamphlets that a friend had made entitled, "How to improve your conversation with people who have impaired hearing." It was done by a friend of his and is based on that one person's experiences.

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Education:

Doctor of Philosophy at Virginia Polytechnic Institute and State University in Marriage and Family Therapy: August, 2000 – Present (Degree expected in May 2003)  
Dissertation: *Acquired Hearing Impairment in Older Couple Relationships: An Exploration of Couple Resilience Processes*

Graduate Certificate In Gerontology from Kansas State University  
August, 1997 – Dec. 2002

Master's of Science at Kansas State University in Marriage and Family Therapy: August, 2000  
Thesis: *Aging and Family Therapy: Exploring the Training, Knowledge, and Clinical Experience of Family Therapists*

Bachelor's of Science at Brigham Young University in Family Science: April, 1997

Research Experience: Principle Investigator

Examining Predictors of Success in Home-based Family Therapy Provided by a Community Service Board.  
New River Valley Community Services,  
Department of Child and Family Services

Graduate Research Assistant at the Center for Gerontology for Dr. Karen Roberto, Assisting with Research on Traumatic Brain Injury Assessment through Virtual Environments.  
Virginia Tech, May 2002 - June, 2002

Graduate Research Assistant, Reminiscence Group Facilitator and Assistant for a Social History Project with Older Adults for Dr. Shannon Jarrott, Virginia Tech,  
August 2000 – May 2001

Graduate Research Assistant at the Center for Gerontology for Dr. Karen Roberto, Assisting with Revisions on the textbook "Community Resources for Older Adults,"  
Virginia Tech, May 2001 - Aug., 2001

Research Experience Continued: Graduate Research Assistant, Observational Data Collection: Horticulture Therapy with Older Adults with Dementia for Dr. Shannon Jarrott, Virginia Tech; May 2001 – Aug. 2001, May 2002 – June 2002

Graduate Research Assistant, Assistant with Montessori Activities for Older Adults with Dementia for Dr. Shannon Jarrott, Virginia Tech, August 2000 - December 2000

Graduate Research Assistant, Focus Group Assistant for Dr. Mark White, Kansas State, June 2000 - July 2000

Graduate Research Assistant, Data Collector and Inter-rater for Kansas Department of Transportation Seat Belt Use Study; May 2000 - June 2000

Graduate Research Assistant/Supervisor in CATI Lab, Kansas State University, for Dr. Robert Poresky; Jan. 1998 - Nov. 1998

Graduate Research Assistant, Senior Care Act Project, Kansas State University, for Dr. Richard Miller; Oct. 1997 - Dec. 1997

Research Assistant, Constructing a Curriculum on Kindness for Prison Inmates, for Dr. Shirley Klein; Brigham Young University, Jan. 1996 - May 1996

Research Assistant, Brigham Young University, Data Entry for Dr. Craig Hart; Jan. 1996-June 1996

Teaching Experience: Graduate Teaching Assistant, HD 3004: Human Development II: Adult Development and Aging, Virginia Tech; August 2001- May 2002

Graduate Teaching Assistant (Instructor), FSHS 510: Human Development and Aging Kansas State University; Fall 1998, Fall 1999, Spring 2000

Graduate Teaching Assistant (Instructor), FSHS 300: Aging and the Family, Kansas State University; May 1999, August 1999

Instructor, Spanish Language, Missionary Training Center; August 1994 - April 1996

Refereed  
Publications:

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Manuscript:

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Yorgason, J.B. (2002, Blacksburg, VA) Paper Presentation, *Making Decisions Between Quantitative and Qualitative Research Methodologies: A Case Example - "Studying Couples in Later Life Where On Partner has Acquired a Hearing Loss"*, Southeastern Symposium on Child and Family Development (Quint State).

Presentations:  
Continued:

Yorgason, J.B. (2002, Ames, IA) Poster Presentation, *Coping and Resilience of Hearing Impaired Older Adults in Couple Relationships: A Pilot Study*, Marriage and Family Therapy Student Research Conference.

Yorgason, J.B., Jarrott, S.E., & Goldstein, C. (2002, Pittsburgh, PA). Sigma Phi Omega Student Paper Presentation, *Enhancing Staff/Participant Relationships Through Group Reminiscence Activities: A Pilot Study*, Association for Gerontology in Higher Education (AGHE).

Jarrott, S.E., & Yorgason, J.B. (2002, Pittsburgh, PA). Resource Exchange (Round Table), *Service-Learning at Dementia Care Programs: A Social History Project*, AGHE.

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Yorgason, J.B., Miller, R.B., White, M.B., & Sandberg, J. (1999, Chicago, Il). Poster Presentation, *Presenting Problems That Couples Bring To Therapy: A View Across The Life Course*, AAMFT.

Nelson, B.S., Wangsgaard, S., Yorgason, J.B., Carter- Vassol, E.L. (1999, Chicago, Il). Workshop, *Clinical Approaches to Single and Dual Trauma Couples*, AAMFT.

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Klein, S., Anglesey, S., Belliston, L., Geddes, K.N., Gibson, G., Hammer, J., Hunt, T., Nilsson, A., & Yorgason, J.B. (1996, Logan, UT). Poster Presentation, *Teaching Kindness in Families*, Utah Council On Family Relations.

Prof. Affiliations:

Student Member, American Association for Marriage and Family Therapy, May 1998-Present.

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Service Opportunities: Student Reviewer for *Personal Relationships*,  
International Society for the Study of Personal Relationships  
June 2001 – Present.

Student Member of the Graduate Policy Committee,  
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October 2001-August 2002.

Member of Planning Committee for Quint State Research  
Conference, Virginia Tech; 2001.

Missionary for the Church of Jesus Christ of Latter-Day Saints,  
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Clinical Experience: In-home Clinician, Intern  
New River Valley Community Services  
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Therapist, Mental Health Association of the  
New River Valley: Pro-Bono Counseling Program  
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Family Therapist Intern, VT Family Therapy Center  
February 2001 – August 2002.

Group Leader for Caregiver's Support Group:  
Virginia Tech Adult Day Services  
September 2000 – March 2001.

Family Therapist Intern, KSU Family Center  
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Case Manager (In-home family therapy),  
Family Preservation of Manhattan, Kansas  
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Bereavement Counselor, Manhattan Homecare and Hospice  
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Adolescent Group Intern Therapist, KSU Family Center  
August 1998 - May 1999.

Premarital Counselor, St. Isidores Catholic Church  
Sept. 1999 - Dec. 1999.

Youth Technician, Provo, Utah; Youth Detention Center  
May 1997 - Aug. 1997.

Honors:

Outstanding Gerontology Doctoral Student Scholarship:  
Virginia Association on Aging; 2002

Center for Gerontology Futures Board Scholarship: Virginia Polytechnic  
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James D. Moran Memorial Thesis/Dissertation Award: Virginia  
Polytechnic Institute and State University; 2002

Eva B. Potter Memorial Scholarship: Kansas State University; 1999

Martha L. Dunlap Memorial Scholarship: Kansas State University; 1998

Outstanding Junior Paper, Phi Kappa Phi Honors Society; 1996

Eagle Scout Award; 1988